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Original Communications.

Sacro-Iliac Strain.

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The subject of strain and relaxation of the sacro-iliac articulation should prove of interest not only on account of the frequency in occurrence, but also on account of the good results that are to be obtained in the majority of the cases, when the treatment is careful and consistent.

The intention of this article is to report a series of cases that have recently come to my notice, but a brief summary of the symptomatology and diagnosis, would seem warranted, in hopes that it may be interesting to those who have had this condition arise in their practice.

Prior to the work done by Drs. Goldthwait and Osgood of Boston in 1905 (1), our knowledge as regards the existence of definite strain and relaxation of this articulation, was meagre. Their experiments and conclusions, based on a large series of cases, have enabled us to arrive at a more definite diagnosis and recognition of the vague and mis-leading pains, often complained of by patients of a certain class

1—Boston Medical & Surgical Journal, May, 1905.

in the lower lumbar region, or small of the back. To this affection the names, *lumbago*, *lumbar rheumatism*, and *crick in the back*, had been ascribed.

In more recent papers, by Drs. Goldthwait and Osgood, (2 and 4) the anatomic and physiologic consideration of this articulation has been taken up.

As is to be suspected, the larger percentage of these cases is found amongst that class of persons whose occupations are those demanding excessive use of the lower group of back muscles and the muscles attached to the pelvic girdle, and so predisposing to the liability of strain. It is not, however, uncommon to find the condition in women, (3) complicating pregnancy and child birth, and in persons who are, or have been, subjected to debilitating illness, requiring treatment in bed, and long continued dorsal decubitus.

In a great many cases, we may look to this condition for an explanation of the post-operative back ache, following the operations demanding complete and general anaesthesia.

A review of the anatomic arrangement of the sacro-iliac joint will show the liability to strain and injury, especially so when the attachment of the pelvic muscles is understood and the ligamentous support of the joint is studied.

To the physicians engaged in practice in the mining sections of our district, I believe this affection is commonly known as the "*coal digger's back*."

The symptoms, together with the past and immediate history, usually give us the diagnosis.

Pain, varying from a dull ache to the most acute degree, is complained of in one or both of the sacro-iliac joints. This pain may follow immediately upon an excessive and quick use of the muscles attached to the pelvic girdle, as caused in lifting heavy loads and in pulling, or may not come on for several hours after the exposure to strain. The appearance of the pain may be slow, as in the strain of any other ordinary joint of the body, where we find the most acute

2—Journal A. M. A., Aug. 31, 1907.

4—A. M. Jour. Orthopedic Surg., July, 1907.

3—Medical Gynecology, Kelly, 1908.

degree of pain coming on several hours after the injury. It is not unusual to hear these patients say that they had had a sensation of weakness in this region following an exertion, as before mentioned, and that they were not inconvenienced by it until the following morning, when, on attempting to "*straighten up*" on arising from the bed, they could not do so without a sharp shooting pain in the small of the back.

Unilateral strain is more frequent than bilateral, and the patient usually has no difficulty in locating the side affected, and when asked will usually place the hand over the exact seat of the pain. However, in some cases, the character of the pain may be dull and constant, and the patient will complain more of a low back ache than of acute pain. This is to be explained on the grounds that the strain may be slight and hardly noticeable, except when such movements are attempted that bring into play the muscles attached to the sacrum and the iliac bones.

It is in the class of cases in which the affection is due to muscular debilitation that we meet with most confusion in our diagnosis, as in nearly all of these cases the development of the symptoms is very gradual. When the condition complicates pregnancy and child birth, the diagnosis is more easily made, and an expectant line of treatment will clear up the symptoms.

When the condition has advanced to a severe chronic strain, we may find a small degree of actual relaxation in the joint, and we might even dare to term it, dislocation. When the structure of the sacro-iliac articulation is understood, it is easy to appreciate the occurrence of such marked symptoms, following a relaxation of the smallest amount. It is rather rare to find a case presenting such relaxation as could be detected in a casual examination.

To fully appreciate the value of the *tests*, as they are called, to diagnose this condition, a thorough understanding must be had of the physiologic and mechanical action of the ligaments supporting this joint, and also the action of the thigh and lumbar group of muscles attached to the pelvic girdle.

The history of the patient, both past and present, is to be taken carefully, with particular attention being paid to the possibility and liability of strain having taken place. This having been done, the tests may be applied.

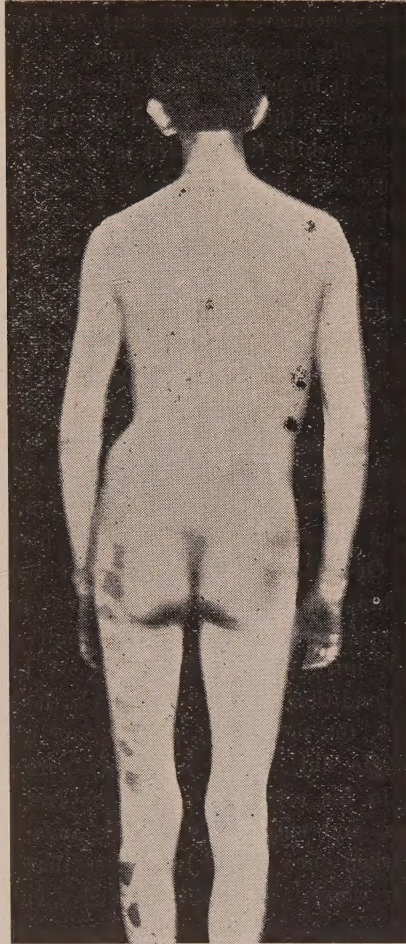
On standing erect, and keeping knees extended, the patient is told to bend directly forward. This is reversed, and we can then estimate the amount of free movement, that is, movement free from pain, and can usually locate by this method the side that is most severely affected. It will also bring out the question as to whether the strain is principally to the anterior or posterior sacro-iliac ligaments.



No. 1. Illustrating the amount of backward bending before treatment was given.

Side bending is next attempted, and we can further locate the painful side.

While these movements are being made, close inspection of the general appearance of the lower back is important, as in some cases we are able to detect a small degree of muscle spasm or muscular attempt to



No. 2. Showing listing to right side and elevation of left iliac bone. The left leg shows some atrophy before treatment.

protect the joint. This is well illustrated in photograph No. 1. It is sometimes well to press the hand over the suspected joint when these movements are being made, and exert considerable force in pressing, as this gives protection to the joint, and will usually allow more movement in bending. Listing to one side is seen in the severer cases, as shown in photograph No. 2.

Probably the most conclusive test is that of *flexing the extended leg on the abdomen*. The knowledge we gain from this movement is sometimes surprising. It brings out more clearly than any other movement, the exact location of the strain, and amount of motion possible. This movement is made while the patient is lying on his back.

This movement may also be reversed, as a test for either anterior or posterior ligament strain, since the reversal of the flexion of the leg brings into play on the pelvic girdle an entirely different group of muscles.

I have made no mention of excluding the possible existence of such lesions in the sacro-iliac joint as arthritis, of various kinds, tubercular invasion or true bone injuries, but it is essential that this be done, if we are to expect rapid improvement to result from our treatment.

For more complete symptomatology, and what is expected to be found in these cases, reference may be had to the following cases:

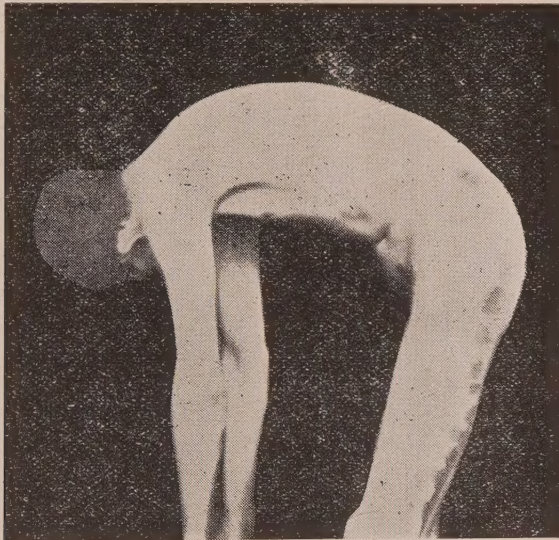
Case 1. J. E. C., male, white, age 28. Occupation, bookkeeper. Family history positive as to rheumatism. Personal history negative,

Present history: On February 23 of this year, patient noticed that it was difficult for him to erect his body on arising in the morning; this difficulty, accompanied by pain in the small of the back grew worse each morning, until he was finally forced to use crutches to support his back. Condition continued through the day and on lying on his back at night, the pain increased, forcing him to turn on his side to get relief. He did not know of any particular exposure to strain, except that in his routine of work, he frequently assisted in moving heavy boxes, and such matter. The invasion of the condition was slow, but when once it had become so that it was noticed by him, it rapidly grew worse. Patient suspected rheumatism, and went to Hot Springs for six weeks, but did not gain any relief, and in fact says that he grew worse. About this time a constant grinding pain was felt in his thigh and calf of his leg, along the course of the

sciatic nerve. This pain was increased on any movement of the back, and became so severe that the patient was forced to take opium to secure sleep at night. The use of the salicylates had been tried by his family physician, and when the pain along the sciatic nerve manifested itself, a *sciatica* was suspected, and the use of the cautery was tried. This gave no relief, and patient's nervous condition was growing worse.

The patient was referred to me by Dr. Cross, on May 23, and the physical examination at that time showed about as follows:

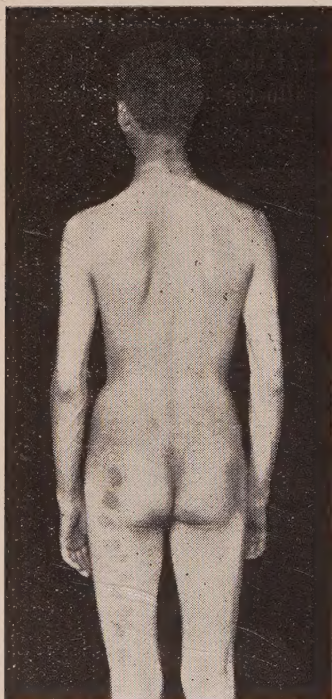
Patient unable to stand erect, and stooped forward, and listed to right side considerably, as shown in photograph. The left leg could not be moved with pain, and showed some atrophy, probably only the atrophy of dis-use, commonly seen. Inspection of the small of the back showed some prominence of the region of the left sacro-iliac joint, and when movements forwards and backwards was attempted, some muscle spasm was seen. The tests mentioned in the first part of article were used, and brought out the true condition of the joint very clearly. The forward bending possible at this time is illustrated in photograph No. 3.



No. 3.

Diagnosis, chronic strain to left sacro-iliac articulation.

Treatment was at once given, which at first consisted of the adhesive plaster strapping of the lumbar region of the back. This gave quite a bit of relief, but not as much as is to be looked for in the average case, so the application of a plaster-of-paris jacket was made, which fitted the pelvic girdle very snugly, and reached upward to about the level of the seventh rib. This was put on with the patient lying supported between two beds, and with the greatest amount of possible extension of the spine in this region. Pressure was made over the joint affected while jacket was being applied, and in this way when jacket hardened pressure was constantly exerted here, and held the joint as snugly in place as possible. This jacket was worn for several days, and removed and a new one applied, this time with more



No. 4. Same patient two months after treatment.



No. 5. Same patient after two months treatment showing increased backward bending.

extension than before. After the application of the second jacket, the patient was able to stand without crutches and walked around the house with comfort, and sleeping was improved, and the use of the narcotics given up. On May the 31, a third jacket was applied and on June 15th patient resumed his work, as bookkeeper, and was able to walk about three miles a day unassisted, and the pain along the course of the sciatic nerve disappeared rapidly. His improvement from this time on was rapid. On June the 25 a fourth jacket was applied. Patient was last seen by me on August the 4, and at that time complained of hardly any pain in the leg and perfect comfort in the back, except on too much exertion. The jacket was removed and a pelvic belt applied. This was sufficient to hold the joint firmly, and patient returned to work. The photographs Nos. 4 and 5 illustrate the improvement in the appearance of the back up to August the 4th.

The prognosis of this case is very good, if patient uses care and follows out treatment until the ligaments of the joint return to their normal condition. The after care and treatment is very important, for when once a strain has been established, the liability of recurrence is marked.

Case 2. T. J. R., male, white age 36. Occupation, professional base ball catcher. Family history negative. Personal history also negative, as to previous joint troubles.

Present history: Patient first seen by me on April 3rd, complaining of pain in the small of the back on arising in the morning and difficulty in standing erect on first arising. This gradually wore off during the day, but when he was at his occupation, that of playing ball, he had difficulty in straightening up when he stooped forward to pick the ball from the ground. He said he had been troubled this way for about a year, and had taken kidney medicine, and rheumatism medicine, with no relief.

Physical examination, did not reveal anything of importance until the tests of the legs and bending were used, and these disclosed a low grade chronic strain of the right sacro-iliac joint.

Treatment: a stout pelvic belt was applied, and patient obtained considerable relief. Exercises were given which tended to strengthen the joint, and the belt was worn constantly.

When last seen by me, about the first of August, he was much improved, was at his occupation, and complained of little or no pain.

Case 3. This case did not occur in my practice, but was reported to me by Dr. R. B. Harkness.

Male, colored, age 40. Family and personal history negative as to other joint involvements. Present history: patient was working at his occupation, that of a coal digger, and was injured on December 15, 1907, by a large lump of coal falling on his back, and striking him in the region of the left sacro-iliac articulation. When first seen by Dr. Harkness, some time after the injury, patient complained of pain in the small of the back in the early morning, which was so severe as to cause him to stop work. The physical examination at that time showed tenderness in the region of the left sacro-iliac joint, and stiffness on bending. An expectant treatment was given, consisting of using a uterine support bandage reversed, that is, the bandage was turned around so that the pressure pad was posterior and the bandage was drawn very tight, and exerted pressure over the joint. This gave relief, and when the patient was last seen, he was back at his occupation, and had had no discomfort for several months. Before the belt was applied his physician had used the adhesive plaster strapping to the pelvis, but on account of the necessity of having to change it so frequently, the bandage was suggested and tried, with good results.

Case 4. Patient referred to me by Dr. Charles M. Nice on Oct. 24, 1907.

Family history negative. Personal history: had severe attack of typhoid fever in August, 1906, and confined to bed four weeks. No complications. A few weeks following recovery from fever was playing, when he was suddenly taken with a severe cramping pain in the small of his back. This condition wore off, until it was only noticed on getting up in the morning and on going to bed at night after having played during the day. This dull pain in the morning and evening continued several weeks when patient was seen by his family physician, and at that time presented a marked degree of listing, to left side, and giving the appearance of a total scoliosis. A brace support was advised and worn, but the condition in small of back did not improve and patient was brought to Dr. Nice, who kindly referred him to me.

On examination at this time, there was nothing to be found by a general examination, except the listing, which had improved considerably. Sacro-iliac strain was suspected and tests applied which showed a bilateral chronic strain to sacro-iliac joints. The diagnosis was made and the lumbar region tightly strapped with adhesive plaster. This was repeated every four days for three weeks, and then a snug fitting pelvic band applied. This gave almost perfect comfort. This was worn continuously, and only removed while bathing. When patient was last seen by me, about two months ago, he was apparently entirely recovered, but still wore belt as a preventative measure.

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Lead Poisoning.*

By Z. B. Chamblee.

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Lead poisoning, plumbism, saturnism, as it is sometimes called, is a form of poison introduced into the system by the alimentary canal by the skin or by inhalation of some of the various forms of lead. The symptoms being disturbed digestion, constipation, lead colic, poor nutrition, anemia, blue line on the gum, pains in the limbs, local muscular paralysis (wrist drop) and wasting and atrophy of muscles.

ETIOLOGY.

The lead is introduced into the system in many forms. Workers in lead, painters and glaziers are particularly prone to it. Miners as a rule escape, but those who work at smeltering furnaces are often attacked. Men who work in white lead factories are especially liable to lead poisoning. In some instances birds that feed on the berries in the neighborhood of lead furnaces are affected.

Again, we have accidental cases that most frequently come from the use of drinking water coming through lead pipes, or which has been stored in cisterns lined with lead. Wine and ciders that contain much

*Read before the Jefferson County Medical Society, June 22, 1908

acid very quickly become contaminated when allowed to remain for any length of time in lead lined vessels.

Among the less frequent causes might be mentioned baking powders adulterated, with the chromate of lead, which is supposed to give to cakes a rich yellow tint. Women are more susceptible than men, children less, according to some men experience.

The lead is rapidly eliminated by the kidneys and skin and is present in the urine of lead workers.

In the way of preventing it, is necessary to give instruction as to how to keep the skin, surface, finger nails, hands, etc., clean. If prevention is impossible in this way, change of occupation is recommended. When occupation is such that most dangers arises from inhalation of the gas, respirators may be tried. Dust should be prevented as much as possible, and the custom of drinking sulphuric acid lemonade is commonly resorted to to render as insoluble as possible the lead.

A certain amount of lead is found in the body normally. J. J. Putman reports of 150 cases in person, showing no signs of poisoning. Traces of lead was found in the urine of 25 per cent of them. In acute lead poisoning we usually have gastro-intestinal symptoms predominating; such as great pain in abdomen, vomiting and symptoms of collapse, frequently not unlike that produced by alcoholism; great diarrhoea and rapidly developing anemia; acute neuritis has been first symptoms noticed; also convulsion and delirium. These cases as a rule rapidly prove fatal.

Probably the form we see most frequently is that due to a chronic condition of poisoning, where patients come to you complaining of colic pains in abdomen. The blue lines on the gums, which is a valuable indication, being due to the absorption of lead in the tissues and converted into the black sulphide by the action of sulphurated hydrogen from the tartar of the teeth. This line is not always present but should be very carefully looked for.

Diarrhoea, or constipation, anemia, atrophy of the muscles, and possibly paralysis, and especially those muscles of the wrist, producing that characteristic deformity of drop wrist. The colic is usually paroxysmal in character and over the whole of the abdomen and is relieved by pressure.

The pulse is increased in tension and the heart's action is usually retarded. Oliver states that the pupils are usually unequal. There are various forms of lead palsy attacking a great number of groups of muscles. Among them being the peroneal type, anti-bronchial, bronchial, Aron-Ducheune and laryngeal forms.

However, there is more frequently a rapid generalization, producing complete paralysis in all the muscles of the parts in a few days. You may have it pursuing a course like ascending paralysis, associated with wasting of all the four limbs. Usually with the onset of paralysis there is pain in the limbs and joints, the so-called saturnine arthralgias. Sensation may remain throughout unaffected. Lead workers are very susceptible to arterio-sclerosis, with a contracted kidney, optic neuritis. or neuro-retinitis may develop.

For chronic cases presenting the above symptoms, the outlook for a complete recovery is bad. In the more severe forms, the patient dies in a very short time. Convulsions is a serious symptom and mental manifestation may remain permanently. Also the various palsies may persist for years and some indefinitely.

TREATMENT.

Possibly prophylaxis is the most important point in the treatment. But in lead workers unless they are exceedingly careful poisoning will occur under the most favorable circumstances. Cleaning of hands, face, finger nails and frequent bathing with the use of respirators when necessary should be insisted upon.

For the colic, hot formication to the abdomen, hyperdermic injections of morphine and atropia when severe pain is present, and the free use of sulph. magnesia, also iodide of potash given 5 gr. doses three times a day is by some considered valuable.

For the various palsies the use of the electric current is recommended, and also massage.

In acute intoxication it is well to empty the stomach by dosage. Large quantities of water should not be used and the fluid should be mucilaginous in order to prevent damage to the stomach, emetics should not be used. The object of treatment being to render the lead as insoluble as possible, magnesium, sodium sulphate, a tonic preparation do this. Milk, mucilaginous drinks and oils should be given, for they have a tendency to protect the mucus membranes, Stimulants are

given when collapse symptoms appear. The bowels should be kept open and mechanically irritating foods avoided.

Of course the patients general condition should be taken into consideration. Fresh air and tonics when necessary and the case treated generally symptomatically, giving the nervous system and kidneys the appropriate remedies.

Conservative Surgery of the Ovaries and Tubes.

By E. M. Robinson, M. D.

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No one will deny that conservative surgery should be practiced under all conditions. We differ only in what we believe to be conservatism. We differ individually in our methods according to our several view points, thus: one operator may believe it is conservative practice to remove every part of all diseased ovaries in all cases, claiming thereby to best protect the future health of the patient. While another thinks that it is conservatism to take chances on the diseased condition and leave a part of any ovary if only a small fragment, provided it be healthy, and they say that it is very rare where all of the ovarian tissue is so diseased as to justify its entire removal. They do not deny the possibility of this leading to a re-opening of the abdomen at a later date for the complete removal of the ovary, but claim it to be a justifiable procedure. We do know that the tendency of ovarian tissue is to heal, and we can leave fragments of any ovary even where abscess exists without bad results and even obtain a healthy functioning condition. It differs in this respect from the same conditions in the tube. If I find a superating condition in the tube there must be some very pressing reason why it should not be removed in its entirety before I will feel justifiable in leaving any part of it. The patient's age, physical, social and financial state should be considered when it comes to the removal of these very important organs, for example, a woman past forty who has children already, especially if she is physically and financially unable to care for more, should not be given

the same consideration as one much younger without children, who would naturally be distressed to know that she was forever barred from performing that function. In a patient suffering from a tubercular condition, either of the pelvic, or of other organs, I should not hesitate to remove the ovary. I would apply this rule in dealing with a malignant condition of the uterus. Bovee, in a paper entitled "Removal of the Ovaries" summarizes as follows: "The existence of an ovarian secretion has not been proven, and therefore, should not act as a bar to oophorectomy. Second, in all cases of removal of the uterus or its body, removal of the ovaries in a woman over forty years of age had best be done. Third, as five per cent of malignancy exists in fibroids brought to operation and in thirty per cent marked complication of the appendages are present, leaving the ovaries when the uterus or its body is removed for such conditions is hazardous to the future well being of the patient. Fourth, in malignant diseases of the uterus and radical surgery is indicated, removal of both ovaries is imperative. Fifth, the indication for removal of the ovaries when partial or complete hystorectomy is done is increasing instead of diminishing. Sixth When ovarian growths of a bilateral nature complicate the hystorectomy both ovaries should be removed, though one seems normal."

Emmet advises (in an article, "When to remove Ovaries") that "on thorough inspection of a suspected ovary anything that does not at once proclaim itself innocent and harmless be removed immediately, and that if a growth, however small, suggests active proliferation, or malignancy, the ovary be taken away in time. Since tumors of the ovary are so prone to malignancy, one in four to six." Norris and others advise the treatment of all such tumors as malignant until proven otherwise. "Bland Sutton in 1897 reversed Tait's procedure in the case of fibroids by removing the uterus and leaving at least one ovary, a procedure which, violently opposed at first, has now become common. His further experience has proven the value of this practice, particularly in women under forty, as being of service in securing freedom from flushing promoting domestic happiness and conserving nubility, notwithstanding sterility." Though the presence of the ovaries, or even the uterus, is not necessary to preserve the sexual instinct. I have records from my own cases where both ovaries have been removed from prostitutes, and they tell me that the sexual desire and

pleasure has in no way diminished, but in some instances it has been increased, perhaps, due to the fact that the presence of diseased organs in the pelvis made the act so painful as to destroy the pleasure of it. I have two cases from which I removed both ovaries and the uterus more than four years ago and they tell me there is no abatement of the sexual desire or pleasure.

Krug reports the history of three cases to show that it is necessary to individualize. It is impossible to generalize he says." (Amer. Jour. Obst., Feb., 1907.) "Baldwin leaves the slightest fragment of ovarian tissue where it is possible, but leaves only such tubal tissue as is beyond question, normal." (Amer. Jour. Obst., Feb., 1907.) "P. Zacharias (Zent. f Gyn., Feb., 1908) refers to a case operated upon by him three years ago by the removal of the greater part of both ovaries, a small portion having been left in situ. The patient has preserved the menstrual function three years after the operation. The author believes that if even some of the connective tissue structures are left behind, menstruation will continue even if there are no follicles left in the tissues. Indications for such conservative operation are found in young women who wish to preserve the menstrual function. Both tumors must be certainly of benign nature and both ovaries must be involved in the growth. The author describes three similar cases in which menstruation continued for two and a half and one and three-quarter years after operation. Pregnancy did not occur in any of them, but the first had gonorrhoea and the last was not married. If there were follicles in the ovarian tissue left in the third patient they may have become atrophied or changed by the continuance of the diseased process." (Amer. Jour. Obst.)

"Brothers (Amer. Jour. Medical Association, Feb. 22, 1908) attempts the difficult task of estimating, upon the basis of 160 cases of conservative adnexal surgery and one post operation death and one case of persistent sinus and urinary fistula, the real value of such procedure. Of 158 cases he has traced eighty-five. Too much stress cannot be laid on reaching some conclusions in this matter, for it is in regard to the guarantee against secondary laparotomy that radical adnexal surgery has a distinct advantage over conservative work. If investigation by other operators based on careful and positive observation should prove that the mortality after conserv-

ative adnexal surgery is so great as to require an unwarranted number of secondary operations then the advantages of preserving ovulation, menstruation, and possible fecundity are clearly out-balanced by the inconvenience if not actual danger of life of a secondary laparotomy. The results which the writer has reached, however, point the other way. He finds that the maximum necessity for secondary operations does not exceed seven per cent. The post operative morbidity he estimates at about 23.5-10 per cent. To attempt to specify the value of conservative adnexal surgery in relieving preoperative symptoms is a very difficult task. Many of these symptoms are purely subjective or relative. What may be described as a burning sensation in the pelvis by one woman will be regarded as intolerable torture by another. The amount of pain which the individual woman actually suffers will be in direct proportion to the development of her nervous system or imagination. Concerning the value of conservative operation for sterility resulting from the lesions of the tubes, ovaries and pelvic peritoneum, he states that he finds notes of only seven and five-tenths of cases with subsequent pregnancy. Yet, even this is regarded as a triumph." (Amer. Jour. Obst.)

"Carmichael has looked into the subject of ovarian grafting from a surgical standpoint. He found that in the rabbit the whole ovary may be transplanted with success. But in the majority of cases (80 per cent) there was partial degeneration of the ovary. It (the ovary) may undergo fibrous or cystic degeneration. The germinal epithelium persists in a small number of cases. The graffian follicles and ova persist and mature some months after grafting, but ultimately tend to cystic degeneration. From these observations he calculates that it is unlikely that the human ovary can be grafted with success, but that partial grafting will be more apt to succeed, the grafting of the cortical portion more especially. Furthermore part of an ovary may functionate, preserve its function of internal secretion." (Jour. of Obs. and G. of the B. E., London.)

"As to leaving the ovaries after removing the uterus Holzbach summarizes three cases that have been published and reports one other in which examination years after the removal of the uterus for cancer. In every instance the finding showed an adequate amount of ovarian tissue capable of functioning, although there was more or less degen-

eration of some of the vessels. He concludes from study of these cases, and from other clinical experience that the ovaries should be left when the uterus is removed, unless their removal is directly indicated. If symptoms of ovarian insufficiency develop afterwards the anatomical findings compel the assumption that the cause of the disturbance does not lie in the ovaries themselves. The reciprocal relations between the various organs of the female generative tract are more extensive he thinks than is generally accepted at the present time. Changes in the nervous apparatus of the pelvis are probably responsible for more of the disturbances generally attributed to the supposed missing ovarian function. The four cases mentioned were distinguished by the severity of the symptoms of the premature menopause after the hysterectomy, notwithstanding the presence of plenty of functioning capable ovarian tissue." (Archive of Gy. na Kologie, Berlin.)

Both tubes may be removed without destroying the function of menstruation. Menstruation may continue after both tubes and one ovary and a part of the other ovary is removed. In dealing with abscess of the tubes and ovaries, I deem it better to do a radical operation, that is by opening the abdomen and thorough removal of the abscess with its sack, than to do the so-called conservative vaginal puncture and drain. By proper care with gauze pads the general peritoneal cavity may be so protected that should rupture occur (which is the rule in cases with dense adhesions) infection will not take place. In quite a number of these cases, especially of long standing, the pus is sterile and should soiling of the abdominal viscera occur infection does not follow. Should the abscess rupture, and if doubt exists as to the closing without drainage, I counter-puncture the vagina through which a phenestrated gauze rubber covered drain is passed and close the abdominal incision. It is often impossible to properly or thoroughly drain a pelvic abscess through a vaginal operation for the reason that there is often partial partition walls in the same abscess or there may be two separate abscesses on the same side, or there may be one or more abscesses on both sides. That patients with pus tubes get well symptomatically cannot be denied, that adhesions remain for a time at least varying in density, is also true, but all symptoms may pass away and the childbearing function be resumed. I have seen more than one case to verify this. There is probably always danger of the inflammation lighting up at

any time, especially if pregnancy occurs. The existence of such a condition predisposes a woman to extra uterine pregnancy. I had a case in May of the present year upon whom I operated for extra uterine pregnancy and upon whom I had made a diagnosis of pustube more than a year ago. In dealing with diseased ovaries with reference to conservative operation upon them, especially if there is marked disease of both, I have had no great occasion to change my views as expressed in an article written and published in the Alabama Medical Journal Feb., 1906. In this article I stated that I have never had the bad nervous symptoms to follow the removal of both ovaries that we are led to believe will occur. These cases are neurotics to begin with and every case that has come under my observation has been benefitted by removing both ovaries, and thus creating the artificial menopause. I have in some cases let conservatism over-ride my better judgment and left an ovary, or part of one, where I was satisfied the patient would be better without either on account of the diseased condition and the patient was not relieved of the symptoms, for which she sought relief and either had to undergo a second operation or continue to suffer. I believe where it is possible to avoid it the ovary should never be sacrificed, but where symptoms and the findings at the operation demand it I think we are justifiable in removing both ovaries. In the very recent work by Kelly and Noble, Kelly says, conservatism of the tube has to do for the most part with inflammations, although such rare conditions as myoma of the tube have been mentioned in this connection. The Ovary may be preserved, he says, "in extra uterine pregnancy, but he always sacrifices the tube beyond its isthmal portion. The peritoneal covering of the tube and its mucosa are brought into contact by continuous or interrupted cat gut sutures.

Auto-Intoxication.*

W. D. Partlow, M. D.,

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As a probable cause of certain conditions that usually follow other forms of toxemia, in such cases as are not preceded by the usual causative poison.

*Read before the Tuscaloosa County Medical Society.

This subject is one that may be looked upon and discussed from many view points to suit the various temperaments. The popular idea at once of the terms "auto-intoxication" ("auto" intoxication) is that familiar sensation experienced when one exceeds the speed limit and is run down by an officer and arrested for the offense, when he only wishes the "auto" had turned "flying machine"—while to other minds "auto-intoxication" would immediately mean some mysterious way of getting round the inconveniences of prohibition by becoming self-intoxicated without having to follow the usual route afforded by alcoholics. Again the term might be construed to suggest that psychological monstrosity termed "paranoia," in which *ego* is so highly developed and prominently in evidence as to keep the individual insanely intoxicated with his self-importance. These phases of the subject, however, I shall eliminate from the discussion here.

To the physician auto-intoxication has a real meaning and is a subject of vast interest. In the treatment of almost every condition the elimination of disease toxins or physiologic waste-products is an important and essential consideration.

In order to study auto-intoxication intelligently and to best advantage, I call attention to the more comprehensive subject toxemia, meaning by this any and all forms of intoxication—a condition in which by some way and from some source a poison or toxine gets into the general circulation.

Toxemia may be divided into three classes of cases:

1. Those which derive their poisons from without, examples of which are lead-poisoning, alcoholism and other forms of drug poisoning.
2. Those in which the toxemia is the result of one of the infectious diseases or of a suppurative inflammatory process, as the toxemia accompanying the various exanthematus fevers, or septicemia, pyemia, sapremia, etc.
3. Those cases in which the toxins are generated somewhere within the body of the individual so poisoned, or auto-intoxication.

There is much in common in classes 2 and 3, and it may be difficult to distinctly differentiate one from the other by description, but in the former the toxemia is merely a concomitant symptom, a result of the disease, a product of infection, as the toxemia in typhoid fever, or empy-

emia; while in the latter auto-intoxication is the disease, the one central and primary condition with its symptoms and possible sequelae.

It is well to note, as we are reasoning by analogy, that the three kinds of toxemia suggested in the foregoing classification differ little if at all as to the real pathologic state of the blood, as in each case the blood is carrying an irritant poison which is being deposited with the various tissues and with which the numerous vascular tissues and organs composing the body are being saturated, by the aid of the intercellular and perivascular lymph spaces, but they differ only as to the character and origin of the poison. Hence with this similarity or almost identity, if there are so many diseased or pathologic states easily referable to, and positively attributed to the various and numerous toxemias in the first two classes (poisons from without and from infectious and inflammatory diseases) why should we not naturally expect and look for many maladies to follow the track of the third class of toxemia, auto-intoxications? There is a set of conditions, nephritis hepatic, cirrhosis, endarteritis, arterio-sclerosis, phlebitis and neuritis, which we expect to be preceded by a more or less chronic toxemia, the constant irritant effect of the poison producing alteration and degeneration of tissue in which every organ may be under consideration. Then if an arterio-sclerosis has no history of syphilis or chronic drink, why not question auto-intoxication as a cause? If a multiple neuritis cannot be attributed to chronic lead, alcohol, or other drug-poisoning, nor is preceded by an infectious disease, why is it not plausible to look for a co-existing causative auto-toxemia?

If any of such conditions are found, that usually or invariably follow a toxemia and the causative toxemia cannot be located in either of the first two classes, why not probably due to the third form of toxemia if the other symptoms of auto-intoxication are present?

Auto-intoxication may come from either of the following two sources:

1. By the absorption from the alimentary canal of poisons which have been generated there by putrefaction or changes in food stuffs usually proteids.

2. By retention in tissues and blood of waste products of tissue change.

The first may be called entero-sepsis, and is usually due to torpid secretions. The secretion from the liver is supposed to inhibit putrefaction and the production of bacteriological toxins in the alimentary canal,

so when this organ is diseased or its function deranged causing scanty secretion, food-stuffs decay, forming poisons which when absorbed produce auto-intoxication. The same condition may also arise from ingestion of an excess of food, more than can be properly digested, absorbed and appropriated so the excess undergoes changes in the intestines producing poisons.

The second form of auto-intoxication is the result of failure of the emunctories to respond to the demands made upon them by the waste products of tissue metabolism, a failure on part of the excretory organs to eliminate the toxins generated by tissue change, allowing these poisons to accumulate and be absorbed and carried by the blood and lymph to all parts of the body. Normally, in health there is at all times a varying degree of auto-blood-poisoning, waste products on their way to be excreted by lungs, skin, kidney, etc. Nature has provided a balance between waste and excretion and it is when the equilibrium of this arrangement is disturbed that we have auto-intoxication of the second type; the exact chemistry of many of the various auto-toxins has not yet been worked out.

Symptoms.—Auto-intoxication may be acute or chronic. As in other toxemias the symptoms of acute auto-intoxication are usually thermic, vascular and nervous. The dizziness, head-ache, slight fever, etc., of the so-called biliousness, the dizzy head-ache, disturbances of vision and convulsions of uremia are examples of acute auto-toxicosis. General torpor of secretions, dry lips, dry, coated tongue, dry skin, scanty high-colored urine, constipation or diarrhea, are symptoms. The circulation of the toxins produce a general disturbance of functions.

The analogy between the effects of toxemias of the first or second class and those of the third is here again apparent. As toxins from without and those from infectious and inflammatory conditions produce first a disorder of function in the organ most susceptible to the particular poison, and then if the source of poison continues to operate and the poisoning is made chronic, we look for organic lesion, degeneration of tissue, etc., where there was first a mere disturbance of function—thus we get the multiple neuritis, hepatic cirrhosis, pseudo-paresis, etc., following long continued drinking of alcohol and the various diseases coming as sequelae to the infectious and contagious fevers, due to the

constant and continued irritant effects of the toxins generated in such diseases, then why not expect similar or identical results from auto-toxemia? In my opinion many of those subacute and chronic diseases such as frequently follow toxemia, such cases as cannot be attributed to a definite poison, are due in many instances to a long continued irritation by auto-toxines. Reasoning in this way from the known toward the unknown, many of the cases often termed ideopathic may be sequelae of auto-intoxication. What has led me to believe as I have indicated is the fact that often cases of arterio-sclerosis (not senile) are found in which both syphilis and alcohol, the usual causes, can be positively excluded, and in which there are evidences of chronic auto-intoxication. Also, cases of nephritis, hepatic cirrhosis, lateral and posterior spinal sclerosis, peripheral neuritis, etc., in which the poisons usually looked for as causes can be excluded and in many such cases I believe auto-intoxication may be the cause.

What has caused me to think along this line more particularly has been a few cases of multiple neuritis which we have had among the women patients at the Bryce Hospital, occurring at different times, and in which the usual poisons, lead, whisky, etc., and infectious conditions could be positively left out of the count. These cases I believe were due to auto-intoxication.

Treatment.—Medicines such as intestinal antiseptics I believe of little or no value. Only such drugs as may stimulate secretions and excretions do good. The kind of remedies and the one to be relied upon more than all others for auto-intoxication is water. Among the recent insane, the one most active and prolific exciting cause, operating of course in those cases inherently predisposed, is auto-intoxication. Especially is this true of acute manias, acute melancholias and precocious dementias. The treatment, thereof is of course to remove the cause by cathartics, followed by gastro-intestinal tonics to stimulate secretions along the alimentary tract and in the adjacent accessory glands. The most clearly indicated, however, is the hydrotherapy—large quantities of water internally—by the mouth if the patient will take it, and if she refuses then water is to be given through the stomach tube, and by normal saline solution by hyperdermoclysis or intravenous injection. By getting large quantities of fluids into the circulation the auto-toxines are diluted and rendered less

noxious, the secretions and excretions are stimulated, the accumulated poisons begin to drift toward an exit and the entire body is flushed, as it were, wherever blood and lymph goes. High enemata of normal saline solution or boric acid solution given daily through a colon tube is often of much value, especially in those cases who take an insufficient quantity of fluids by the mouth. Of the cases of mental troubles which we may hope to benefit by treatment, a very large percentage comes within the class of auto-toxemia as the exciting cause.

I append here report of one case of peripheral neuritis:

Mrs. D——, age 37 years, has been in the hospital six years—farmer's wife. Her father was a farmer by occupation—never called peculiar, eccentric or weak-minded. Was addicted to the use of alcoholic drinks. Patient's father and mother related. Mother's history negative. Has one brother living and three dead. Four sisters are living. Patient's history during childhood normal. Had several attacks of excitement previous to the one for which she came to the hospital. Condition when admitted—acute mania. Present mental condition—chronic dementia.

Physical health had been very good since admission until about July 1, 1907. She was seen to be running down in health, having coated tongue, bowels constipated, poor appetite. On July 7, 1907, she was placed in bed, general run down state of health, extreme auto-intoxication, temperature 99 F to 101 F, pulse variable and irregular, severe pains in both feet and legs and hands and forearms with hyperesthesia—burning, tingling sensations with numbness, symmetrical in both upper extremities to the elbows and both lower extremities to the knees, also marked tenderness over the extremities, the patient crying out with pain if touched or moved. Edema was also present being more marked in the feet and legs than in the hands and forearms. By Aug. 13, 1907, the sensory symptoms had gradually changed, the general hyperesthesia and severe pains gradually giving way to a local anaesthesia in the areas affected, showing less acuteness of the senses of touch and pain. Along with the sensory anaesthesia came motor symptoms until there was almost complete loss of motion in both legs and forearms, with dropped, everted feet and dropped wrists; the patient being unable to stand or walk. Very gradually and slowly the motor paralysis disappeared until within about four months from the onset the patient walked and used her hands naturally.

This is one of a number of similar cases treated occurring at different times within the past four years, having apparently no connection one with another as to cause, and in all of which the usual causes, lead, alcohol and other drugs, also malaria and infectious conditions, were excluded.

It is the rule for mutiple neuritis to be preceded by a prolonged intoxication or toxemia of some one of the numerous types. In these cases auto-intoxication was present and all other forms of toxemia absent, therefore the neuritis must have been a symptom or sequel of auto-intoxication.

Fused or Horseshoe Kidney.

Byron Robinson,

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For ten years I have been collecting illustrations, museum and autopsic specimens of fused or horseshoe kidney. At present I have collected eighty-four illustrations, no two of which are identical. It is to be regretted that the general profession views the anomaly of fused or horseshoe kidney as a curiosity. Rather should the fused kidney be regarded as variations of diagnostic and clinical importance. In the blooming of renal and ureteral investigations it is time to study fused kidney from a physiologic, anatomic, pathologic, clinical and surgical standpoint. The most practical and instructive method to study fused kidney is from specimens and from illustrations drawn from specimens, for a picture tells a thousand fold better than a definition. The literature of fused or horseshoe kidney is limited.

Physiologically the fused kidney experiences no disturbance in function. It lives a physiologic life exactly as non-fused kidney. It has no

special influence on well being of its possessor. The non-fused or horseshoe kidney refers to abnormal form and not to abnormal function. The fused kidney is developed from normal parenchyma. Urinalysis furnishes no clue to fused kidney. From mechanical factors pathologic renal physiology may arise though statistical data are not at hand to prove it.

Anatomically it may offer grave disturbances. Mechanically it may interfere with adjacent and remote structures, anatomically and physiologically. Its position may jeopardize it to trauma. The embryological renal parenchyma may lie in such proximity that fusing or coalescing occurs, resulting in interference of form and position. The ureters possess normal collecting uriniferous tubules; though distorted in anatomic arrangements as flexion, constriction.

Pathologically the fused kidney is liable to require medical assistance because its abnormal position renders it liable to trauma and disease. Its position in general is ventral to the lumbar vertebrae, occupying a distalward position in the abdomen. In woman it might suffer for trauma during parturition or gestation. In both sexes it may suffer from trauma from exposed position or constipation.

Clinically the fused kidney is of vast significance in *diagnosis* and in surgery. It may be mistaken for abdominal neoplasm, tumor. I know of no date which recorded a diagnosis of fused kidney previous to extra or intraperitonotomy. I know of three surgeons—one in New York; one in Louisville; one in Chicago, who while performing peritonotomy discovered a horseshoe kidney. Each retired successfully without removing the mass. And yet fused or horseshoe kidney occurs perhaps once in 5,000 subjects. The x-ray is the hope for diagnosis of horseshoe kidney.

Surgically fused kidney is of extreme importance on account of: (a) multiple abnormal renal vessels with haemorrhage tells the story of surgery in fused kidney; (b) vessels are not only abnormal in multiplicity, but also in position and dimension. The abnormally located vessels become lacerated and the source of haemorrhage is obscure. (c) A danger in surgery of fused kidney is the removal of the whole or part of the fused kidney before the diagnosis is complete or relations are discovered—with fatal results; (d) occasionally the entire

fused renal mass may be located dorsal to the vena cava and aorta, endangering the integrity of the great vessels of the abdomen by any kind of surgery, (e) the renal isthmus may be located at the proximal or distal renal termination or in the center, and it may be located ventral or dorsal to the vena cava and aorta. Fused kidney presents more lobulation than the normal one—presenting a condition of arrest of development in contour, form and location.

Definition.—A horseshoe kidney consists of the fusion or coalescence of: (a) the proximal renal pole—*renes arcuati proximal*—or (b) the fusion of the distal renal pole—*renes arcuati distal*, by means of a segment of renal parenchyma or connective tissue, known as an isthmus, which extends across the vertebral column; (c) a third kind is that in which two lateral renal masses are coalesced, united, by a median segment—a crucial or circular form, *renes compositae*.

A horseshoe kidney signifies coalescence or fusion or renal parenchyma from opposite sides of the body, or the same side. Foetal lobulation indicates that the kidney is a composite organ and has coalesced bilaterally separate. The malformation in horseshoe kidney has no constant informity of manifestations. The fused renal masses are irregular in contour, form, blood supply, dimensions, location and visceral relations.

The form of horseshoe kidney is extremely variable, however, I have classified it, for convenience, into three departments, viz., (a) *renes arcuati proximal*, i. e., the proximal poles are fused; (b) *renes arcuati distal*, i. e., the distal renal poles are united; (c) *renes compositae central*, i. e., there is a central coalesced renal mass. Horseshoe kidney presents extreme variation, in position, extending from the coeliac axis to the pelvic floor; practically a fused or horseshoe kidney presents congenital renal dystopia. Renal vessels influence the position of the segments of the renal mass to an extensive degree. The dimensions of the horseshoe kidney varies extensively, however, perhaps it averages as equivalent to normal bilateral renal unicity. The hilus renalis and sinus renalis also vary extensively. An important subject is the visceral relations of the horseshoe kidney, which possesses marked individuality. The fused or horseshoe kidney must be considered anatomically, physiologically, clinically, pathologically and surgically.

General Remarks.—The factors to study in fused (horseshoe) kidney are:

1. *Position.*—The horseshoe kidney is the most frequent form of renal fusion and the most common form of renal dislocation (dystopia). It may be located from the celiac axis to the pelvic floor, unilateral or bilateral to the vertebral column.

2. The *form* of the fused kidney is important in diagnosis and regard to adjacent visceral relation (syntopia).

3. *Dimension* is significant on account of adjacent visceral relations.

4. The *renal isthmus* is important on account of its location and of its relations to the great abdominal vessels and ureters.

5. *Visceral relation* is important, especially during gestation and parturition, as well as its relation to the functions of the tractus intestinals.

6. *Vasa renalia* present important matters in regard to horseshoe kidney, e. g., as to number, dimension (length, diameter), location.

7. The jeopardy of the horseshoe kidney is greater in woman than man (on account of menstruation, gestation, parturition).

8. One of the important factors in horseshoe kidney is the ureteral relations. An x-ray of metal catheterized ureters aids in diagnosis.

9. An important factor is to maintain in mind that any person may possess a horseshoe kidney. The accompanying illustrations, figures

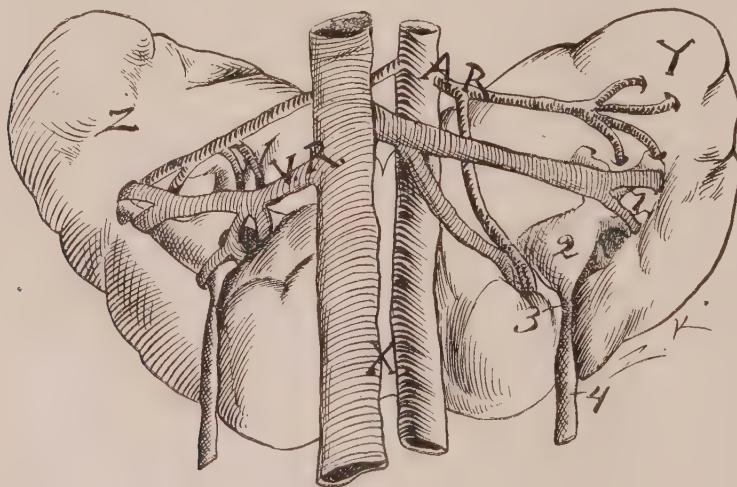


Fig. 33. Fused (Horseshoe) Kidney.

(33), (39), (83) and (84) with short legends chosen at random from my eighty-four illustrations will suggest a significant story to the physician.

Renēs arcuati distal (distal renal poles fused) *Explanation of illustration signs.* Z, right and Y left lateral renal mass. A. R., arteria renalis. V. R., vena renalis. X, isthmus renalis. 1. Calyces. 2. Pelvis ureteral. 3. Proximal ureteral isthmus. 4. Ureteral dilatation (lumbar spindle). *Presentation.* Ventral view. *Isthmus renalis.* X, parenchymatous. Dimension liberal renal fusion. Location, directly dorsal to aorta and vena cava, but directly ventral to vertebral column. Ureters and isthmus renalis are on the same side of the aorta and vena cava (i. e., dorsalward).

Hilus Renalis.—Bilateral hilus unicity and nonsymmetry (as to form, position, dimension). Located, on ventral renal surface. It receives all renal vessels, except one branch of left artery which with four prongs penetrates the renal parenchyma similar to accessory renal arteries. Form, irregular, distorted with non-definitive boundary. Dimension, liberal, illdefined. *Sinus renalis segment of extensive sphere or plane.* *Ureter proprius.* Bilateral ureteral unicity and symmetry (as to position, form, dimension). Location, on ventral renal surface. Form (isthmuses—3 and dilatations—1, 2, 4) marked. Dimension and course, normal. *Pelvis ureteris.* Bilateral pelvic unicity and symmetry (as to position nonsymmetry (as to form, dimension)). Location, on ventral renal surface. Dimension, within normal range. Form, distorted. *Calyces ureteris.* Not exposed. Right 3, left 5. Bilateral calicular unicity and nonsymmetry (as to form, position number dimension). Location, on ventral renal surface. Distribution, irregular. *Vasa renalia* Bilateral vascular unicity—2, and symmetry (as to position number) paired. Vascular bifurcation adjacent to origin. The vascularity indicates calicular duplicity. All renal vessels enter hilus except a left proximal branch with four prongs, which penetrates the parenchyma similar to an accessory renal artery. Renal vein ventral to renal artery. *Topography.* Holotopia, excessively medianward and distalward. Skel-etopia, abnormally intimate with the vertebral column and distal lumbar vertebrae. Syntopia, excessively intimate with aorta and vena cava. Idiopia, excessive rotation of proximal and distal renal poles. *Form.* Crescentic, elongated transversely. Compressed dorso-ventrally, *Sym-*

metry. Practically symmetrical bilaterally. *Surface.* Lobulated, fissured. *Dimension.* Equivalent to two (limited) normal kidneys. *Position.* Dystalward congenital renal distopia. (Presented to me by Dr. H. T. Howe of Chicago, Ill.)

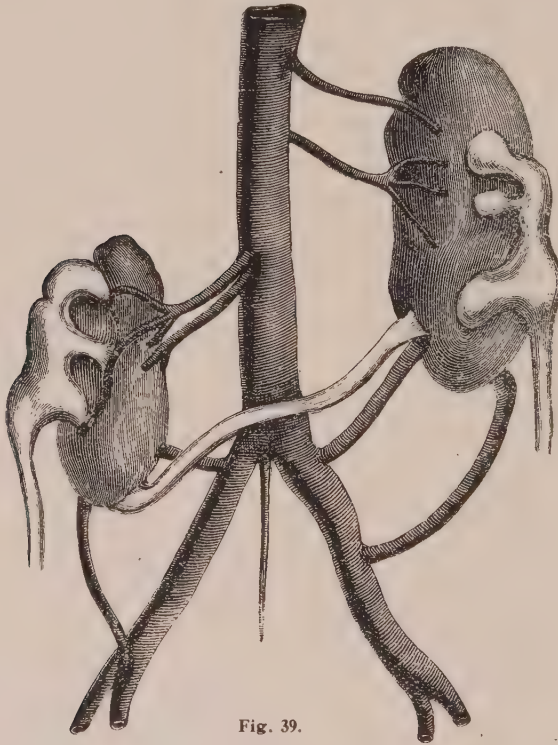
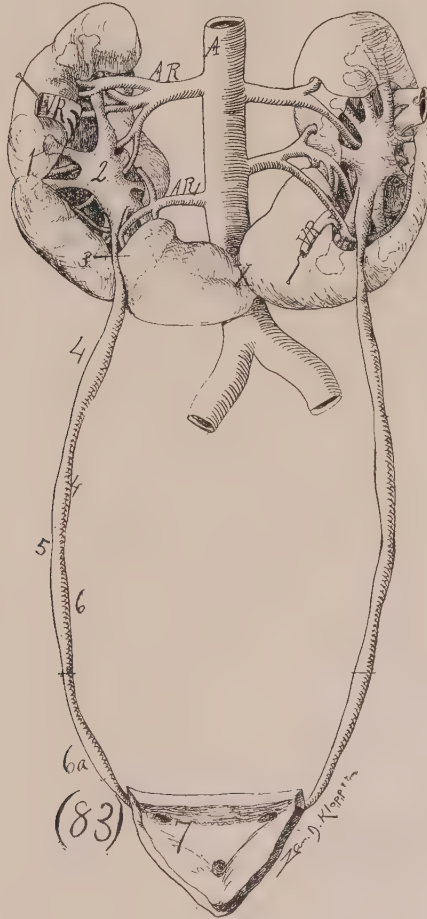


Fig. 39.

Fig 39.— Fused (horseshoe) kidney. *Renes arcuati distal* (poles fused at distal end). *Explanation of illustration signs.* *Presentation.* *Ventral view.* *Isthmus renalis.* Fibrous. *Dimension* minimum renal fusion.

Location, at distal renal poles also directly ventral to aorta and vena cava, but directly dorsal to ureters. Both ureters and renal isthmuses are located ventral the vasa abdominalia magna. *Hilus renalis.* *Bilateral* hilus unicity and nonsymmetry (as to form, position, dimension). *Location,* on ventral renal surface. *Form,* irregular, distorted. *Di-*

mension, liberal. *Sinus renalis*. Limited renal excavations. *Ureter proprius*. Bilateral ureteral unicity and nonsymmetry (as to position) symmetry as to form, dimension). Form (isthmus, dilatation) marked. Dimension, normal. Course, distorted. *Pelvis ureteris*. Bilateral pelvic unicity and nonsymmetry (as to position, form, dimension). Location, on ventral renal surface. Form, irregular. distorted. Dimension, moderated. *Calyces ureteris*. Bilateral calicular unicity and nonsymmetry (as to position, form, dimension). Location, on ventral renal



surface. Dimension, normal. Distribution, irregularly distributed. *Vasa renalia*. Bilateral arteria quadruplicity and nonsymmetry (as to position). The renal arteries arising from the common iliac are paired bilaterally, those originating from the aorta are not paired. *Vasa renalia* from the iliac do not enter the hila, those from the aorta only partially enter the hila. The renal organs have experienced rotation which is no doubt due to the influence of the bloodvessels on the renal labia. *Topography*. Holotopia, excessively distalward and medialward location. Skeletopia, abnormally intimate with vertebral column and sacrum promontorium. Syntopia, excessively intimate with vasa abdominalia magna. Idiotopea, renal organs rotated on axis. *Form*. Distorted. *Symmetry*. Bilateral nonsymmetry, the left renal mass tends proximalward. *Surface*. Lobulated, fissured. *Dimension*. Equivalent to two kidneys. *Position*. Distalward congenital renal dystopia. (From A. H. Young and Thompson.)

Fig. 83.—Fused (horseshoe) kidney. *Renes arcuati* distal. *Hila renalis* located on the ventral renal surface due to the larger renal blood vessels hypertrophying the dorsal renal labia and rotating them ventralward. Adult male.

Explanation of illustration signs.—A, aorta. VR, vena renalis. 1. Calyces. 2. Ureteral pelvis. 3. Proximal ureteral isthmus. 4. Larger and smaller lumbar spindles. 5. Middle ureteral isthmus. 6 and 6a. Pelvic ureteral spindles. 7. Vesicle ureteral orifice. Ventral view,

Isthmus renalis.—X, fibro-parenchymatous. Dimension, medium. Location at distal renal poles ventral to vasa abdominalia magna and dorsal to ureters. Both ureters and renal isthmus are located ventral to the aorta and vena cava.

Hilus renalis.—Bilateral hilus unicity and nonsymmetry. Location on ventral renal surface. Form, bilaterally nonsymmetrical in contour, irregular. Dorsal renal labia hypertrophied. Dimension, liberal bilateral nonsymmetry.

Sinus renalis.—Bilateral nonsymmetry in form, dimension. Limited renal excavation.

Ureter proprius.—Bilateral ureteral unicity and symmetry (as to position, form, dimension). Location, in ventral renal surface. Form bilateral symmetry (as to isthmuses and dilatations). Dimension, bilateral symmetry, normal range,

Pelvis ureteris.—Bilateral pelvic unicity and nonsymmetry (as to position, form, dimension). Location, on ventral renal surface. Form, bilateral nonsymmetry. Contour, left regular, right irregular. Dimension, bilateral nonsymmetry, liberal especially on right.

Calyces ureteris.—Bilateral calicular unicity and nonsymmetry (as to number, form dimension, distribution). Number, right 9. left 8. Form, normal, bilateral nonsymmetry. Dimension, normal range, bilateral nonsymmetry. Location on ventral renal surface, bilateral nonsymmetry as to distribution.

Vasa renalia.—Bilateral vascular duplicity and nonsymmetry (as to

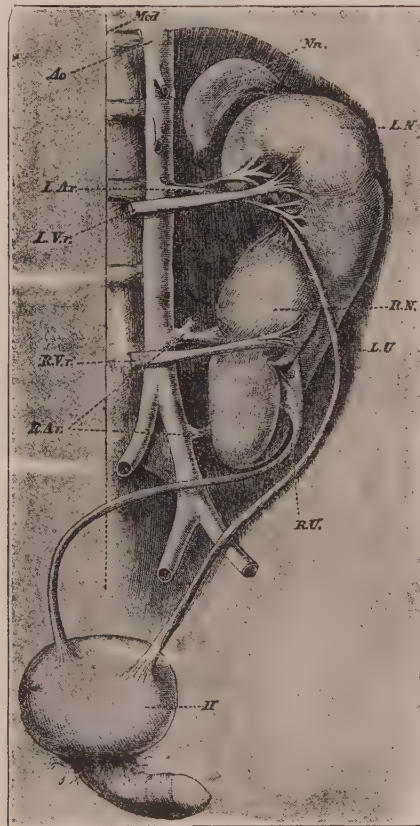


Fig. 84.

position). The renal veins and arteries are paired. All vessels enter the renal hila. The kidneys are rotated in such a manner that the renal hila present ventralward (instead of medianward as in the normal state). The renal rotation is due to excessive blood supplied to the dorsal renal liabia hypertrophying them with consequent rotation.

Topography.—Holotopia, location is excessively distalward and medianward. Skeletopia, abnormally intimate with vertebral column, os innominata and os sacrum. Syntopia, abnormally intimate with vasa abdominalia magna. Idiopia, renal organs excessively rotated on axis. *Form*, distal pole distorted. *Symmetry*, bilateral nonsymmetry. *Surface* reniform. *Dimension*, equivalent to two kidneys. *Position.*—Distalward and medianward congenital dystopia. (This specimen was presented to me by Dr. Warren Hunter of Chicago. Ill.)

Fig. 84.—Fused (horseshoe) kidney. Renes arcuati distal. Ren sigmoideum. S-form. Adult male.

Explanation of illustration signs.—Med., median line. Ao, aorta. L. Ar., left renal artery. L. Av., left renal vein. Nn., supra renal capsule. Ln, left kidney. Rn, right kidney. R. Vr, right renal vein. R. Ar, right renal artery. L. V, left ureter. R. V, right ureter. H, bladder. Ventral view polar fusion. In this subject the fusion (i. e., the renal isthmus) occurred between the proximal pole of the right kidney and the distal pole of the left kidney.

Isthmus renalis is extensive, located dorsal to the left ureter, and left of vasa abdominalia magna.

Hilus renalis.—The hilum of the left kidney is directed rightward and that of the right kidney leftward. This is due to rotation of the right kidney.

Sinus renalis simulates normal kidneys except as to position of left kidney.

Ureter proprius unilaterally duplicate. The proximal ureter passes ventral to the isthmus renalis and left of the distal renal pole of the right kidney. The form of the ureter (isthmuses and dilatations) not reported. Ureteral course distorted. Length, proximal ureter elongated. right (or distal) ureter contracted.

Pelvis ureteris.—Unilaterally duplicate with reversed or opposite positions. Form, distorted. Dimension, normal.

Calyces, not exposed. Unilateral calicular duplicity. Location, normal.

Vasa renalia.—Left kidney (proximal) vascular unicity. Left kidney (distal) two arteries and one vein.

Topography.—The sigmoid renal mass was located from the eleventh dorsal to the fifth lumbar. Holotopia, excessively leftward and distalward. Skeletopia, excessively distalward. Syntopia, abnormally related to the sigmoid flexure. Idiopia, the renal mass possesses an S-form. Form, ren sigmoideum.

Symmetry, unilateral nonsymmetry. Surface reniform. Dimension, equivalent to two kidneys. *Position*, distalward and leftward congenital renal dystopia. (Illustration from Dr. G. S. Booesika, Berlin, Germany.)

Tetany.

By Geo. L. Faucett,

Gadsden, Ala.

Tetany is described by various authors as a motor neurosis, a disease, a mere disorder due to several pathological factors. It is probably of toxic origin and bears close relationship to rickets. Strange it seems that rickets is so common while tetany is seldom met with in this country.

Tetany is perhaps more common than our statistics indicate, there being less than one hundred cases reported in the United States up to the present date.

In offering a paper on this subject I shall attempt only to present a case that occurred in my practice which I diagnosed and treated as a case of "tetany," and I hope to impress the readers of this journal sufficiently to cause them to look out for this affection, as I am convinced that it is far more prevalent than we think.

On April 8, 1908, I was called to see a colored boy, C. S., eight years old. He was complaining of stiffness in feet and legs and could walk with difficulty. I noticed that any mechanical stimulus produced strong contractions of the lower extremities. My suspicion was aroused. A few points noted excluded tetanus; there was no history of any injury;

the masseters were not involved; the muscular contractions were intermittent, and there was no elevation in temperature as is usually the case in tetanus. Strychnia poison was as easily excluded and tetany was suspected.

By inquiry and observation the following data was elicited:

Family history: Father and mother living and in good health. No history of lues, insanity, nor tuberculosis could be obtained. Parents had had only diseases of childhood and father had malaria. Patient had had whooping cough only. He walked at nine months old.



For several months previous to the attack, patient had been in poor surroundings. His father deserted the family in mid-winter, leaving the mother with four children to feed, clothe and furnish house with fuel to heat. To economize, she kept the children in bed day and night

to keep warm as she had no coal. They were often without food, and the day before seen, the patient was liberally fed on scraps of cheese by a neighbor. That night he was suffering with his stomach and was given (wisely) a full dose of castor oil which gave relief, but when symptoms of stiffness occurred I was called. On my first visit there was no elevation of temperature, although the mother said the child had high fever the night before. The tongue being heavily coated, I gave course of calomel and waited for developments.

Returning the next day I found the condition much worse, apparently every voluntary muscle being involved. Patient lay in opisthotonus position with face turned to one side, emaciated, pupil reacts to light and accommodates to distance, marked lacrymation, face shows typical sardonic grin, can open and shut mouth, profuse sweating, especially over forehead, small ulcers on tongue and buccal cavities. Joints are not enlarged and bones normal in shape; chest normal in shape, abdomen distended and umbilicus greatly protruded.

He lies with elbows a little outward, forearms across the chest, the hands in the accoucher position. The thighs are adducted, toes turned inward and foot extended so that when stood up he stands on tip toes. (Notice position in figure.) When left alone has momentary spasms from one to five minutes apart. Any movement or stroking of the body causes violent muscular contractions; also pressure over large nerve trunks produces spasms. Electricity was not tried.

Between the attacks he lies quietly and the muscles completely relax. By the third day the muscles became very sore and each contraction caused a sharp cry. The patient on the second day was unable to walk or even stand unaided. When on his back a hand placed under his heels and raised up would produce no bending of the body or limbs, with one hand under his head and the other under his feet and lifting the body it remained perfectly stiff and straight. The stomach was found to be very much dilated.

This patient was put on a liquid diet, consisting of broths, albumen water and lemonade for a few days until the intestinal symptoms were improved and the appetite returned. As soon as possible he was put on a full nutritious and easily digestible diet and kept on it till dismissed. The appetite was good throughout the course after it first

returned. The muscular spasm was controlled as much as possible by full doses of bromides and chloral. The disease was worst from the third to tenth day, after which it gradually subsided, recovery being complete in about twenty-five days.

Three months later the boy seems to have no trace of symptoms present.

CONCLUSIONS.

1. Tetany must be more frequent than we suspect in this country.
2. The attack in the case reported was brought on by long continued starvation, close confinement, bad air and precipitated by the over eating of cheese that produced auto-intoxication.
3. There was no evidence of rickets in this case.
4. The treatment should consist of measures directed toward elimination of the toxins, aiding the digestion, and controlling the spasms.
5. The diet should be nutritious and easily assimilated.

A STERILE EYE BATH.

An eye bath fashioned from a single piece of aluminum has been introduced by the Kress & Owen Company.* That this little device will be well received by the medical profession is not to be questioned when one considers the many points of advantage this metal cup has over the old style glass contrivance. It is cleanly, unbreakable, and can be sterilized instantly by dropping into boiling water. The surgical bag in the future will hardly be complete without one of these cups which will give happy results in many an emergency. It will be found invaluable for treating ophthalmia, conjunctivitis, eye strain, ulceration and all inflammatory conditions affecting the eye.

Directions.—Drop into the eye bath ten to thirty drops of Glyco-Thymoline; fill with warm water. Holding the head forward, place the filled eye bath over the eye, then open and close the eye frequently in the Glyco-Thymoline solution. No pain or discomfort follows the use of Glyco-Thymoline. It is soothing, non-irritating, and reduces inflammation rapidly.

*One of these eye baths will be sent free upon request.



Editorial.

W. H. BELL, M. D., Editor.

The Journal will be mailed on or about the 15th of the Month. Subscribers failing to receive it promptly will please notify us at once

We cannot promise to furnish back numbers

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The editor is not responsible for views expressed by contributors.

All communications should be addressed to
**THE ALABAMA MEDICAL JOURNAL, 109½ N.
20th St., Birmingham, Ala.**

The International Congress on Tuberculosis.

One of the most important scientific congresses ever held in America, The International Congress on Tuberculosis, will be held in Washington this fall. The sessions will be held September 21 to October 12, 1908. This congress will mark an epoch in the anti-tuberculosis movement in this country. This will be the first meeting ever held in the United States. It meets triennially. The last meeting was held in Paris in 1905.

Distinguished men, the most eminent authorities on the tuberculosis problem in our own land and from other countries, will take part in the discussions. Official delegates will be present from nearly all the civilized countries.

In connection with the congress a great tuberculosis exhibit is to be held, illustrative of what is being done around the globe in the fight against tuberculosis. The exhibition and the section meetings will be housed in the new National Museum, adjoining the Smithsonian build-

ings. The congress will be divided into seven sections, giving ample scope for the participation of both scientific and lay members. These sections are, 1st, Pathology and Bacteriology, Dr. Wm. H. Welch, Baltimore, President; 2nd, Clinical Study and Therapy of Tuberculosis—Hospitals, Sanatoria and Dispensaries, Dr. Vincent Y. Bowditch, Boston, President; 3rd, Surgery and Orthopedics, Dr. Chas. H. Mayo, Rochester, Minn., President; 4th, Tuberculosis in Children—Etiology. Prevention and Treatment, Dr. Abraham Jacobi, New York, President; 5th, Hygienic, Social, Industrial and Economic Aspects of Tuberculosis, Dr. E. T. Devine, New York, President; 6th, State and Municipal Control of Tuberculosis, Surg.-Gen. Walter Wyman, Washington, President; 7th, Tuberculosis in Animals and its Relation to Man, Dr. Leonard Pearson, Philadelphia, President.

President Roosevelt has accepted the presidency of the congress, and Dr. Edward L. Trudeau, of Saranac Lake, has been made honorary president. Vice-President Fairbanks, Speaker Cannon and the governors of the States have agreed to serve as vice-presidents of the congress.

There are two classes of members: Active members, who pay a fee of \$5.00, and associate members, who pay a fee of \$2.00, and have all the privileges of membership, except the right to vote and to receive the printed volumes of transactions. Alabama has only twelve active members at the present time. New York has 522 and Pennsylvania 362. Thus it is seen Alabama is far short of the number of members she should have. We urge all who are interested to write to the secretary-general, Dr. John S. Fulton, 714 Colorado Building, Washington, D. C., and become members. The Medical Association of the State of Alabama at its last meeting in Montgomery authorized its president to appoint fifty delegates to attend this congress. In compliance with this authority, the president, Dr. B. L. Wyman, has made the following appointments as delegates: S. G. Gay, Selma; H. G. Perry, Greensboro; G. S. Barksdale, Fernbank; W. E. Howell, Haleyville; H. P. McWhorter, Collinsville; A. J. Coley, Alexander City; D. L. Wilkinson, Montevallo; L. W. Johnston, Tuskegee; J. M. Whiteside, Anniston; G. T. McWhorter, Riverton; W. H. Bell, Birmingham; R. B. Harkness, Birmingham; R. M. Cunningham, Ensley; C. C. Jones, East Lake; J. F. Alexander, Blocton; L. W. Deprez, Florence; M. B. Cameron,

Eutaw; W. D. Partlow, Tuscaloosa; S. W. Welch, Talladega; E. B. Ward, Selma; Wm. W. Dinsmore, Decatur; J. S. Crutcher, Athens; Wm. J. Clark, Russellville; T. J. Dean, Union Springs; F. E. Baldridge, Huntsville; P. B. Lusk, Guntersville; H. L. Appleton, Gadsden; Mason Foshee, Brewton; P. I. Hopkins, Clanton; Chas. A. Mohr, Mobile; A. M. Stovall, Jasper; B. F. Rea, LaFayette; J. G. Palmer, Opelika; C. W. Hilliard, Dothan; E. Bonner, Camden; D. S. Brockway, Livingston; G. B. Wimberly, Reform, F. C. Stevenson, Montgomery; H. B. Wilkinson, Montgomery; T. H. Frazer, Mobile; Geo. H. Fonde, Mobile; W. T. Pride, Madison; Hugh Boyd, Scottsboro; M. S. Davie, Dothan; J. P. Stewart, Attalla; A. L. Wynn, Floralla; Julius Jones, Rockford; H. W. Blair, Sheffield; S. C. Tatum, Centre, and W. H. Robertson, Clayton.

The railroads will give rates from this State of one fare and three-fifths for the round trip on the certificate plan. All the delegates and members are urged to attend.

Anti-Tuberculosis Meetings of County Societies.

Dr. B. L. Wyman, President of the State Medical Association, and Dr. W. G. Harrison, both of this city, recently visited the Walker County Medical Society at Jasper and the Tallapoosa County Medical Society at Alexander City. At both places most interesting meetings were held, attended by the laity as well as the profession of the counties. The principal subject discussed was tuberculosis. Interesting addresses were made by the visitors as well as by others.

It is the intention of President Wyman to visit other county societies during his term, these visits to have as their object the further education of the people on the prevention and cure of tuberculosis, and the stimulation of greater interest in both the laity and profession in the fight against the "great white plague."

We believe great good can be accomplished by these meetings and would be glad if they could be arranged to be held in every county of the State. While it may not be practical for the president to visit all the counties during his term, we suggest that all arrange for the meetings and have as many of the laity as possible to attend them, and other speakers can be had to address them on this subject. Let the

warfare begun in Alabama not cease until all the people are convinced that consumption can be prevented and, under proper conditions, can be cured here at home.

By the way, it seems to us that it is time for further movement to be taken for the establishment of the sanatorium for the tubercular authorized by the last legislature. The governor appointed a most competent board of trustees in April, and it seems to us that the appropriation should be forthcoming to enable this board to proceed. Let the governor be urged by those of the profession who are within his councils to allow no further delay in this important matter.

Doctors Licensed by the State Board.

At the examinations before the Alabama State Board of Medical Examiners held in Montgomery in June and July there were one hundred and thirty-eight applicants. Of these there were sixty-six successful ones, or 47.82 per cent. of the number who applied. A list of those who passed successfully follows:

James Ernest Walker, Clema; Murray Cobb Hollis, Sulligent; William J. Warren, Sumpterville; John C. Moore, Hamilton; J. W. H. Herrman, Autaugaville; W. R. Smith, Florala; B. L. Green, Gadsden; J. C. Morrison, Tallassee; J. A. Minus, Ridgeville, S. C.; J. E. Harden, Rockford; R. E. Peebles, Birmingham; D. H. Finlay, Pollard; C. A. Jackson, Brightwater; J. J. Pettus, Madison; D. R. Cornelius, Birmingham; H. H. Henderson, Butler Springs; Huey Watson, Banks; J. P. Long, Birmingham; A. M. Richards, Baker Hill; K. B. Williams, E. more; W. H. Brothers (colored), Montgomery; Emily Blakeslee, Sandusky, O.; N. E. Cashin (colored), Decatur; A. L. Stabler, Thorsby; William Robertson, New Decatur; O. C. Mastin, Citronelle; S. F. Nabers, Birmingham; T. A. Gunn, Calera; C. W. Mixon, Bowles; W. W. McGehee, Montgomery; E. W. Cawthon, Mobile; J. R. Armistead, Marvin; W. L. Shackelford, Columbus, Miss.; W. E. Wright, Warrior; D. S. Moore, Jr., Birmingham; S. C. Seay, Pratt City; F. V. Meriwether, Andalusia; D. H. Wright, Corona; J. S. Norton, Birmingham; E. S. Miller, Talladega; C. C. MacClean, Florala; J. U. Reaves, Anniston; H. A. Greenwood, New Orleans; B. S. Lester, Guthrie, Ky.; H. K. Tippins, Brewton; S. L. Burdeshaw, Headland; C. W. Farrar, Birm-

ingham; S. R. Sanders, Birmingham; H. G. Camp, Talladega; R. C. Speir, Furman; E. W. Rucker, Jr., Birmingham; H. P. Shugarman, Birmingham; S. W. Thorn, Memphis, Tenn.; W. L. Andrews, Beatrice; J. W. Fleming, Jr., Montgomery; B. F. Adams, Mobile; S. F. Nash, Brookwood; H. E. Pearce, Birmingham; E. P. Hogan, Birmingham; E. A. Hendricks, Birmingham; H. H. Sorrell, Brookside; J. M. Carr, Fort Deposit; S. S. Busby, Drifton; H. G. Owen, Bessemer; F. J. Lee, Pine Hill; A. E. Orton, Adison.

A Visitor to the British Medical Association.

We take the following from the "Yorkshire Telegraph and Star," Sheffield (Eng.), of Saturday, August 1st. Many of our readers will no doubt recognize the letter as being written by Dr. Geo. S. Brown, of this city, who with his wife has been spending the past several months in Europe. The letter will be of interest to his many friends here, hence we give it in full:

AS OTHERS SEE US—MEDICAL VISITOR TO SHEFFIELD— IMPRESSIONS OF CITY AND PEOPLE—AN INTERESTING LETTER.

A distinguished medical man, hailing from the United States, who has been visiting Sheffield during the past week for the purpose of attending the conference of the British Medical Association, sends us today, on the eve of his departure, the following interesting and gratifying communication:

To the Editor of the "Yorkshire Telegraph and Star."

Dear Sir:—I am one of the undistinguished visitors to the British Medical Association. My heart is filled with gratitude for the many benefits that have come to me this week through the uniform courtesies of the English physicians, the board learning and great achievements of the British people, and through the boundless kindness and hospitality of the people of Sheffield. I know my thanks are of little moment to these, my kind friends of the week, but I cannot help expressing them to you, and I hope you will accept them.

The industrial turmoil of this great city has impressed me in a degree that will abide with me for long. It is all great, but to the med-

ical mind the breaking strain of these workshops is almost a tragedy. At first we wonder how the human machine can survive it at all, and then comes the thought that these are all skilled workmen, artisans, many of them artists, and that they live in the fierce excitement (it may be joyful or it may be painful), and that the drudgery that kills is in a comparatively small degree. Such work sustains individual pride, and the man is at his best.

Through the beneficial, the humanitarian, activities of the newspapers, much of the work and discoveries of my profession as voiced by the members of the great British Medical Association have this week been brought before the people of this great city, but in this connection it is a matter of profound regret that the learned and nobly intended address of Doctor Owen, at the Albert Hall last night, did not meet with the encouragement it deserved. Backed and upheld as it was by the personal influence and presence of such intellectual and humanitarian princes as the Lord-Mayor, the Master Cutler, and the Public Health Officer, the hall was (purely I am sure by some error of the management) not half filled. This seeming slight to the speaker and his supporters is not chiefly the thing we regret, but it is that the hall was not filled to the doors with the foremen and the intelligent leaders of your huge industrial army. Few of them own evening suits, but they lead and influence their men more than any others, be they owners, masters, ministers, or even their family doctors. It was a grave oversight that will cost human lives in these next few months that this unfashionable, but sturdy bone and sinew element of your country did not hear Doctor Owen's address last night, and if a humble foreigner's advice had any weight he would suggest that Dr. Owen be asked to repeat his address, and that tickets (as it seems nothing can be done without tickets) be issued to factory foremen only. I am sure they are numerous enough in this huge hive to fill the Albert Hall. They can do more than all others to regulate ventilation and control spitting.

It was my pleasure to be one of a crowd today to see the workshop of John Brown and Co., and the process of making armour plate. As I have not one single acquaintance in the city of Sheffield, I was more than gratified to find myself talking with an unusually fine-looking, intelligent, and altogether attractive gentleman at my elbow. There

were no introductions, but with the quick eye of the polished and kindly gentleman, he saw I was inquisitive and a stranger, and with that perfection of tact for which I am sure he is famous, he, in a few moments, satisfied my curiosity about those steel-making processes in a manner that made me suppose steel-making was his business, and so smoothed away those awkward feelings which cause a stranger to fear he may be intruding as to make me perfectly happy. In a few moments I learned quite casually that my hospitable friend was none other than that eminent Democratic nobleman, your Lord Mayor of Sheffield. It is good to have a man like that strolling about when an awed and lonely stranger can stumble upon him. Good for the stranger, at any rate.

To improve the condition of the workmen it is most necessary to have the co-operation of the workmen, and under the leadership of such men as your Lord Mayor and Master Cutler a strong effort is being made to educate the men in this direction because it is now recognized that masters in the past have too often made this lack of co-operation in the workmen an excuse for doing nothing themselves. Under such leadership the world is learning that the wise must be the keepers of their ignorant brothers. Noblesse oblige! The rich, the good, the wise, all have their added responsibilities. Thank God, our medical profession stands highest in this regard. We accept the duty of teaching all who will learn. There is no limit to the number added to our ranks, and we hold such meetings as this grand one just come to a close for mutual improvement to the end of benefiting mankind. If our patient is difficult to deal with, and through ignorance will not co-operate with us, we merely regard that as a complication of the case and deal with it as best we may. Let us hope that much good may grow, and continue to grow in improving the condition of the working man. That hope and the recollection of Sheffield's hospitality will make one of the bright weeks in the life of at least one

Sheffield, August 1.

American Visiting Surgeon.

Dr. W. P. Spratling.

The following from a Baltimore daily will be of interest to the Alabama friends of Dr. W. P. Spratling, who is a native of this State:

"It was announced at the College of Physicians and Surgeons last night that the vacancy in the chair of physiology and nervous diseases at that institution will be filled in September by Dr. William P. Spratling, now head of the Craig Colony for Epileptics at Sonyea, N. Y. The vacancy was caused by the recent death of Dr. George J. Preston."

The Southern Infirmary.

The attention of our readers, especially those of Southern Alabama, is called to the advertisement of the Southern Infirmary. This institution is located in Mobile and is under the able management of Drs. T. H. Frazer and W. R. Jackson. It is a modern, up-to-date institution for the treatment and care of surgical, gynecological and obstetrical cases, and has proven to be a success in every particular. We commend it to the doctors as worthy of their patronage.

TITLES OF PAPERS FOR SECTION I OF THE INTERNATIONAL CONGRESS ON TUBERCULOSIS.

Dr. William H. Welch, President.

(Includes titles received up to August 13.)

Milton J. Rosenau, Washington, D. C.—"The Viability of the Tubercle Bacillus."

Victor C. Vaughan, Ann Arbor, Mich.—"A Study of the Proteids of the Tubercle Bacillus."

John Weinzerl, Seattle, Wash.—"The Action of Diffuse Light Upon Bacillus Tuberculosis."

Dwight M. Lewis, New Haven, Conn.—"The Morphology of the Tubercle Bacillus."

S. Arloing and Paul Courmont, Lyons, France.—"Nouvelles Cultures Homogenes des Bacilles de la Tuberculose."

J. N. Davalos and J. Cartaya, Havana, Cuba—"Comparative Study of the Tubercle Bacillus of Human and of Bovine Origin."

A. Rodet, Montpellier, France—"La Virulence de Bacille dans ses Rapports Avec l'evolution Clinique de la Tuberculose Pulmonaire."

A. Parker Hitchens, Glen Olden, Pa.—"A Chamber in which Dried Tubercle Bacilli May be Handled Without Danger."

N. Ph. Tendeloo, Leyden, Holland—"Channels of Infection."

Julius Bartel, Vienna, Austria—"Über Eintrittspforten der Tuberculose."

G. Kuss, Angicourt, France—"Sources et Voies d'infection de la Contagion Tuberculeuse."

S. Bernheim, Paris—"Les Portes d'entree de la Tuberculose."

S. Bernheim, Paris—"Rapports de l'air avec la Contagion Tuberculeuse. Sterilization de l'air."

Alfred F. Hess, New York—"A Study of the Tuberculous Contamination of New York City Milk."

Jules Courmont and A. Lesieur, Lyons, France—"Inoculation Transcutanee de la Tuberculose."

Julius Bartel, Vienna—"Immunisirungsversuche Gegen Tuberculose."

Jules Courmont and A. Lesieur, Lyons—"Contribution a l'immunité dans la Tuberculose."

A. B. Marfan, Paris—"Immunité de l'homme pour la Tuberculose."

Y. Ishigami, Osaka, Japan—"Tuberculo-Toxoidin and Immunisation Serum."

Eugene L. Opie, New York—"The Part of Enzymes in Tuberculous Lesions."

Alfred S. Warthin, Ann Arbor, Mich.—"The Frequency of Healed Tuberculosis of the Mesenteric Glands, With Particular Reference to the Relationship Between Hyaline Deposits in these Glands and the Healing of Tuberculous Lesions."

S. Arloing, Lyons, France—"De l'infection Tuberculeuse d'après le Criterium Anatomo-Pathologique."

John McCrea, Montreal, Canada—"Analysis of 1,000 Consecutive Autopsies in Montreal With Reference to the Incidence of Tuberculosis in the Different Organs."

A. R. Landry, Montreal, Canada—"Incidence of Chronic Pleurisy in 1,400 Autopsies in Montreal, and Its Relationship to Tuberculosis."

Leon Barnard, Paris—"Etude Anatomique et Pathologique des Lésions Non-Folliculaires de la Tuberculose."

R. Tripier, Lyons—"De la Pneumonie dans le Processus de la Tuberculose Pulmonaire."

J. Paviot, Lyons—"Processus Anatomique de l'hémorrhagie dans la Tuberculose au Debut."

Joseph Walsh and C. M. Montgomery, Philadelphia—"The Kidneys in Tuberculosis of the Lungs."

D. J. McCarthy, Philadelphia—"Tuberculosis of the Spinal Meninges, With a Consideration of the Mode of Infection of these Structures."

J. T. Ullom, Philadelphia—"The Liver in Tuberculosis."

Walter Altschul, Prague, Austria—"Zur Pathologie der Peritoneal-Tuberkulose."

Charles Esmonet, Puy de Dom.—"De la Tuberculose Experimentale du Testicule."

O. Amrein, Arosa, Switzerland—"Periostitis et Adipositis Tuberculosa Toxica Multiplex."

Paul Courmont, Lyons—"Proprietes Humorales des Exsudants Tuberculeux, Valeur, Pronostique et Therapeutique."

Camillo Calleja, Valladolid, Spain.

Alfred C. Crofton, Chicago—"An Experimental and Clinical Study of the Calcium Metabolism in Tuberculosis."

LIST OF SPECIAL LECTURES.

In connection with the International Congress on Tuberculosis a series of special lectures will be delivered in Washington and elsewhere by eminent foreigners. The names of the speakers, and the cities in which they will lecture follow:

Bernard Bang of Copenhagen, Washington, October 3—Subject: "Studies in Tuberculosis in Domestic Animals and What We May Learn Regarding Human Tuberculosis."

A. Calmette, of Lille, France, Philadelphia, September 26—Subject: "Les Nouveaux Procèdes de Diagnosis Precoce de la Tuberculosis."

Emil Coni of Buenos Ayres, Washington, October 2—Subject: "La Lucha Contra Tuberculosis en la Republica Argentina."

Arthur Newsholme of Brighton, Washington, September 29—Subject: "The Causes which have led to the past Decline in the Death Rate From Tuberculosis and the Light Thrown by this History on Preventive Action for the Future."

Gotthold Pannwitz of Berlin, Philadelphia, September 24—Subject: "Social Life and Tuberculosis."

R. W. Philip, Edinburg, Boston, October 6—Subject: "The Anti-Tuberculosis Programme—Co-Ordination of Preventive Measures."

C. H. Spronck of Utrecht, Boston, October 7.

Andres Martinez Vargas of Barcelona, New York, October 9—Subject: "Tuberculosis of the Heart, Blood and Lymph Vessels."

Theodore Williams of London, Philadelphia, September 25—Subject: "The Evolution of the Treatment of Pulmonary Tuberculosis."

Dr. Maurice Lutelle and M. Augustin Rey (joint lecture), Washington, September 30—Subject: "La Lutte Contra la Tuberculosis dans les Grandes Villes par l'Habitation; Methods Scientifiques Modernes Pour sa Construction."

Dr. L. Landouzy of Paris, Baltimore, October 5.

Dr. A. A. Vladimiroff of St. Petersburg, Washington, September 28—Subject: "Biology of the Bacillus."

Prof. N. Ph. Tendeloo of Leiden—Subject: "Collateral Tuberculosis Inflammation."

THE SAMPLE EVIL.

Enough attention is not paid in some of the northern towns to the practice patent medicine distributors have of sowing samples broadcast on the doorsteps of the people. In some cities ordinances exist against this practice, but elsewhere the public sentiment has not been sufficiently stirred to enact local legislation against it. Pills, powders and herbs are frequently scattered over the porches and doorsteps, and, because of the brightness of the preparations and their aromatic flavor, children regard them as candy, and do themselves great injury by eating them. Such drugs as acetanilid, morphine, cocain and strychnin, are contained in many of these preparations, deftly concealed beneath the sugar coating. Perhaps if we had women in our city councils, they would take more interest in preventing this evil than is now taken by the men, who, presumably, have things of greater moment to discuss and consider,—*Ex*,

Personal Notes.

Dr. Geo. H. Stubbs and family have returned from a visit to Boston.

Dr. John A. Wyeth, of New York, is spending his usual summer vacation at his old home in Marshall county.

Dr. U. J. W. Peters has returned from a stay of several months in Europe, where he has been doing post-graduate work.

Dr. E. Laurence Scott, of this city, left on the 15th inst. for Boston to do two months study in his special line of orthopedics.

Dr. James S. McLester, 830 South Twentieth St., Birmingham, wishes to announce that he will be absent from his office for purposes of study October 1, 1907, to October 1, 1908.

Dr. B. D. Sibley announces that he has moved his office to the second floor of the First National Bank Building, rooms 227 and 228, where he will continue the practice of eye, ear, nose and throat work.

Announcement has been made of the approaching marriage of Dr. Courtney W. Shropshire, of this city, to Miss Leta M. Deffy, of Jeffersonville, Ind., which is to take place at the home of the bride on Sept. 21st. The Journal extends congratulations.

PHYSICIANS ATTENTION!

Drug stores for sale on easy terms, etc., United States, Mexico and Canada. Drug store position. F. V. Kniest, Omaha, Nebraska.

NOTICE TO DOCTORS.

For Sale—A Wagner Four-plate Static Machine.

Guaranteed to be in *first-class* condition in every respect; no tarnish about it, as it has been handled carefully and given systematic attention. Get as good or better results from its use than when it was new.

Reason for selling is to get out of therapeutic x-ray work and do only surgical x-ray work. Have been in it ten years and developed an x-ray dermatitis and must quit. For price and other particulars, address or call on

J. R. Goodloe, M. D., Demopolis, Ala.

Book Notices.

Pain, Its Causation and Diagnostic Significance in Internal Diseases.
By Dr. Rudolph Schmidt, Ass't in the Clinic of Hofrat Von Neusser, Vienna, Translated and Edited by Karl M. Vogel, M. D., Instructor in Pathology, Col. of Phys. and Surg., Columbia University; Clinical Pathologist and Ass't. Attending Physician, St. Luke's Hospital and Hans Zinsser, A. M., M. D., Instructor in Bacteriology, Col. of Phys. and Surg., Columbia University; Ass't. Pathologist, St. Luke's Hospital. Philadelphia and London. J. B. Lippincott Company. \$3.00, net.

This book is a systematic analysis of pain and the author has performed a useful service to the profession in writing it. It will serve as a guide to the practitioner in the rapid and correct interpretation and successful treatment of the pain occurring in internal diseases. It is a concise and thorough presentation of the subject, the author in its writing calling upon the experience of many years with a great deal of clinical material. The translators have done their work well, and have added a chapter giving a brief presentation of Head's researches on referred pains and a series of diagrams showing some of the commoner seats of pain or tenderness in visceral disease.

International Clinics. A Quarterly of Illustrated Clinical Lectures and especially prepared original articles on Treatment, Medicine, Surgery, Neurology, Paediatrics. Obstetrics, Gynecology, Orthopaedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene, and other topics of interest to students and practitioners. By leading members of the medical profession throughout the world. Edited by W. T. Longcope, M. D., Philadelphia. Volume II. Eighteenth Series, 1908. J. B. Lippincott Company. Philadelphia and London. 1908.

This is an interesting volume, as are all of the *International Clinics* that have been issued. Among the good articles of this number we mention only a few: The Treatment of Scarlet Fever. by Louis Fischer, M. D.; Two Years' Experience of Treatment by the Inoculation of Bacterial Vaccines, by Edward Turton, M. D.; The Clinical Manifesta-

tions of Uterine Cancer, by John A. Sampson, M. D.; Gonorrhoea and Pregnancy, by Ernest Boyen Young, M. D., and Recent Research into the Pathology of Malignant Disease, by Charles E. Simon, M. D.

Golden Rules of Dietetics. The General Principles and Empiric Knowledge of Human Nutrition; Analytic Tables of Foodstuffs; Diet Lists and Rules for Infant Feeding and for Feeding in Various Diseases. By A. L. Benedict, A. M., M. D., Buffalo, Member of American Academy of Medicine, and of American Gastroenterological Association, etc. Author of Practical Dietetics. C. V. Mosby Medical Book and Publishing Company, St. Louis. 1908. \$3.00.

This is one of the Medical Guide and Monograph Series, a neatly bound book presenting the general principles and details of the science and art of dietetics. Diet being a most important factor, both in health and disease, in the proper care and management of the body, it is well for the physician to have convenient and succinct rules for guidance. These can be found in this book, and we commend it as worthy a place in every physician's library.

Diagnosis By The Urine, or the Practical Examination of Urine With Reference to Diagnosis. By Allard Memminger, M. D., Professor Chemistry and Hygiene and Clinical Prof. of Urinary Diagnosis in the Medical College of the State of South Carolina, etc. Third Edition, Enlarged and Revised with 27 illustrations. Philadelphia. P. Blakiston's Son and Co., 1012 Walnut St. 1908. \$1.00, net.

This third edition of this splendid little volume has been carefully revised by the author. Only a little more matter has been added, the author adhering to the original idea of not making the book too bulky. There are 116 pages. It will prove a great help to students and a safe guide to the busy general practitioner, to whom we commend it.

Reference and Dose Book. By C. Henri Leonard, A. M., M. D., Emeritus Professor of Gynæcology in the Detroit College of Medicine. New and enlarged edition; 40th thousand. Cloth, limp sides, round corners, thin paper, 16mo., 145 pages; price, 75 cts. The Illustrated Medical Journal Company, Publishers, Detroit, Mich.

The changes in the new edition of the U. S. Pharmacopœia are given in this edition of "Leonard's Dose Book" in two groupings, one showing those of "Increased Strength," the other of "Decreased Strength," and the new doses for these changes. All the Dose List has been carefully "proof-read" by several different readers, so as to insure absolute accuracy in the (nearly) 4,000 remedies given. The U. S. Dispensary has been followed for medium and maximum dosage. The common name (in small type) is given after the drug name and dose. Besides this complete Dose List, the book has numerous useful Tables and a therapeutic index.

This new edition has been printed on thin paper so as to make it adaptable for buggy case or "bag," the whole being only one-fourth of an inch thick, and weighing only about three ounces. Its round corners and smooth linen covers also make it "easy carrying" in the pocket. With this little book at hand you need never be at a loss for accurate dosage (new or old style) of a remedy.

BOOKS AND PAMPHLETS RECEIVED.

Biennial Report of the Board of Health of the City of New Orleans. 1906-1907. Brandao Printing Co. 1908.

The Chaille Jubilee, And Annual Report of the Dean of the Med. Dep't. of the Tulane University of Louisiana. New Orleans.

The Eighteenth Annual Report of the Eye, Ear, Nose and Throat Hospital. 1907. New Orleans.

The Sphere of the Trained Nurse. W. A. Newman Dorland, A. M., M. D. Philadelphia.

An Appeal for a Square Deal. By N. C. Abbott, M. D. Chicago.

Hygienic Laboratory—Bulletin No. 37.

Index Catalogue of Medical and Veterinary Zoology. Subjects: Trematoda and Trematode Diseases. By Chas. Wardell Stiles and Albert Hassall. Washington, Gov. Print. Office. 1908.

Hygienic Laboratory—Bulletin No. 40.

1. *The Occurrence of a Proliferating Cestode Larva in Man in Florida.* By Chas. Wardell Stiles.
2. *Re-examination of the Type Specimen of Filaria Restiformis Leidy, 1880.* By Chas. Wardell Stiles.
3. *Observations on Two New Parasitic Trematode Worms.* By Chas. Wardell Stiles and Joseph Goldberger.
4. *A Re-examination of the Original Specimen of Taenia Saginata Abietina (Weinland, 1858).* By Chas. Wardell Stiles and Joseph Goldberger. Washington, Gov. Print. Office. 1908.

The Cultivation and Handling of Golden Seal. By Alice Henkel, Ass't., and G. Fred Klugh, Scientific Ass't., Drug Plant Investigations, U. S. Dep't. of Agriculture. Bureau of Plant Industry, Circular No. 6. Washington, Gov. Print. Office. 1908.

Wholesale Prices 1890-1907 Industrial Hygiene. Bulletin of the Bureau of Labor. Dep't. of Commerce and Labor, No. 75, March, 1908. Washington, Gov. Print. Office.

A Primer of Wood Preservation. Forest Service, Circular 139. U. S. Dep't. of Agriculture. By W. F. Sherfese, Forest Ass't. Washington, Gov. Print. Office. 1908.

Influence of Food Preservations and Artificial Colors on Digestion and Health. Benzoic Acid and Benzoates. By H. W. Wiley, M. D., with the Collaboration of W. D. Bigelow, chief of the Division of Foods, F. C. Weber, and others. Issued July 20, 1908, U. S. Dep't. of Agriculture, Bureau of Chemistry. Bulletin No. 84. Part IV. Washington, Government Printing Office. 1908.

Mortality Statistics. 1906. Seventh Annual Report. Dep't. of Commerce and Labor. Bureau of the Census, S. W. D. North, Director. Washington, Gov. Print. Office. 1908.

Diagnosis of the Common Skin Diseases of Childhood. By W. B. Brown,

M. D., New York. Reprint from *The Journal of Obstetrics*. Vol. lvii., No. 6. 1908.

A Case of Diphtheria In Which 498,000 Units of Antitoxine Was Given.
By W. K. Sutherlin, M. D., Shreveport, La. Reprint from *Medical Record*, Jan., 1905.

The Influence of Flesh-Eating on Endurance. By Irving Fisher, Ph. D., New Haven, Conn. Reprint from *Yale Med. Jour.*, March, 1907.

Treatment of Gastric Ulcer. By Theodorus Bailey, B. S., M. D., New York City. Reprint from *American Medicine*, March, 1908.

The Submucous Operation on the Nasal Septum. By J. E. MacKenty, M. D., New York City. Reprint from *American Jour. of Sur.*, May, 1908.

The Hydriatic Method in the Treatment of Cardiac Disease. By J. H. Kellog, M. D. Reprint from *Modern Medicine*. Vol. xvii. 1908.

Abscess of Uterus; Hysterectomy; Recovery. By Gaston Torrance, M. D., Birmingham, Ala. Reprint from *Jour. A. M. A.*, July 11, 1908.

The Surgical Treatment of Perforating and Duodenal Ulcers. By Gaston Torrance, M. D., Birmingham, Ala. Reprint from *Mobile Medical and Surg. Jour.*, May, 1908.

The Value of an Absolutely Vegetarian Diet in Psoriasis. By L. Duncan Bulkley, A. M., M. D., New York. Reprint from *Jour. A. M. A.*, Feb. 22, 1908.

Radio—Active Baths in the Treatment of Malaria. By E. H. Martin, Hot Springs. Reprint from *Transactions Miss. State Med. Association*.

Oxygen in Medicine and Surgery. By W. S. Bainbridge, A. M., Sc. D., M. D., New York. Reprint from *N. Y. State Jour. and Med.*, June, 1908.

The Submerged Tonsil with Special Reference to Cervical Adenitis and Systemic Infections. By Lee M. Hurd, M. D., New York City. Reprint from American Medicine, July, 1908.

Tuberculosis of the Tongue. With Report of a Case. By Wm. M. Harsha, M. D., Chicago. Reprint from Surgery, Gynecology and Obstetrics, March, 1908.

Purulent Pyelitis Treated By Lavage of the Renal Pelves. Report of Six Cases. By Winfield Ayres, M. D., New York. Reprint from the International Jour. of Surgery, May, 1907.

The Influence of Alcohol on the Opsonic Power of the Blood. By Chas. E. Stewart, M. D., Battle Creek, Mich. Reprint from Modern Medicine, November, 1907.

The Relation of Appendicitis to Gynecological Pelvic Diseases. By S. W. Bandler, M. D., New York. Reprint from Med. Record, April 11, 1908.

Further Studies in the Treatment of Tuberculosis Sinuses. Fistulous Tracts and Abscess Cavities. By Emil G. Beck, M. D. Chicago. Reprint from the Ill. Med. Jour., July, 1908.

MELAENA NEONATORUM WITH REPORT OF A CASE CURED BY TRANSFUSION.

Samuel W. Lambert. New York, gives the history of a case of mælaena neonatorum that had nearly proved fatal when transfusion of blood from the father's veins accomplished a rapid cure. He goes over the various theories of the causation of this disease, and sums them up by saying that no satisfactory theory has yet been arrived at. The most satisfactory is that of lesions of the capillary blood-vessels, the cause of which may be an infection.—*Medical Record*, May 30, 1908.

Cold fresh air cures disease day and night, for it invites blood and blood cures disease.—*Byron Robinson*.

Miscellaneous Notes.

ASSISTANT SURGEON—FREEDMEN'S HOSPITAL.

SEPTEMBER 2-3, 1908.

The United States Civil Service Commission announces an examination on September 2-3, 1908, at the places mentioned in the list printed hereon, to secure eligibles from which to make certification to fill a vacancy in the position of first assistant surgeon (male), Freedmen's Hospital, at \$1,500 per annum, and vacancies requiring similar qualifications as they may occur at that hospital.

The examination will consist of the subjects mentioned below, weighted as indicated:

<i>Subjects.</i>	<i>Weights.</i>
1. Letter-writing	5
2. Anatomy and physiology	10
3. Surgery and surgical pathology	20
4. Chemistry, materia medica, and therapeutics	5
5. Bacteriology and hygiene	5
6. Theory and practice of medicine and general pathology....	25
7. Obstetrics and gynecology	15
8. Experience (practice)	15
Total	100

Applicants will be given credit for practical experience according to length and character. Maximum credit will be given only to those who have had three or more years' experience in private practice or two years' experience in hospital work or dispensary service.

The examination will be divided as follows: First day, first four subjects; second day, remaining subjects.

Age limit, 20 years or over on the date of the examination.

This examination is open to all citizens of the United States who comply with the requirements.

The Freedmen's Hospital is an institution for the treatment of colored patients, and it is understood to be the practice of the Department to appoint only colored persons to positions therein.

Applicants should at once apply either to the United States Civil Service Commission, Washington, D. C., or to the secretary of the board of examiners at any place mentioned in the list printed hereon, for application Form 1312. No application will be accepted unless properly executed and filed with the Commission at Washington. In applying for this examination the exact title as given at the head of this announcement should be used in the application.

As examination papers are shipped direct from the Commission to the places of examination, it is necessary that applications be received in ample time to arrange for the examination desired at the place indicated by the applicant. The Commission will therefore arrange to examine any applicant whose application is received in time to permit the shipment of the necessary papers.

Issued July 22, 1908.

CLINICAL DIRECTOR—GOVERNMENT HOSPITAL FOR THE INSANE—AUGUST 26, 1908.

The United States Civil Service Commission announces an examination on August 26, 1908, to secure eligibles from which to make certification to fill a vacancy in the position of clinical director in the Government Hospital for the Insane, at a salary of \$2,000 per annum, with maintenance in the Hospital, and vacancies requiring similar qualifications as they may occur in any branch of the service.

No merely scholastic or clerical tests will be given, and competitors will not be assembled for examination.

The examination will consist of the subjects mentioned below, weighted as indicated:

<i>Subjects.</i>	<i>Weights.</i>
1. Education, training and experience	70
2. Publications	30
Total	100

To become eligible in this examination, the applicant must be a graduate of a regular incorporated medical college, must have had at least ten years' experience in institutions for the care and treatment of the insane, during which period he must have received training with special reference to work along clinical lines, in research work, in pathology,

and in psycho-pathology. He must have contributed to medical literature on the general subject of insanity, or some of its phases, or with report of cases coming under his observation. He must have a fair reading knowledge of at least one foreign language, preferably German.

The appointee, in his capacity as clinical director, will have general supervision of all the medical work of the Hospital; the supervision and care of the hydrotherapeutic departments, operating room and the training school for nurses; all transfers of patients from one service to another will be made through him; will have charge of the clinical records and see that they are uniformly maintained, and be in a position to offer suggestions that recent medical literature may contain along the lines of clinical psychiatry.

Age limit, not over 35 years on the date of the examination.

This examination is open to all citizens of the United States who comply with the requirements.

This announcement contains all information which is communicated to applicants regarding the scope of the examination, the vacancy or vacancies to be filled, and the qualifications required.

Applicants should at once apply to the United States Civil Service Commission, Washington, D. C., for application Form 304 and special form. No application will be accepted unless properly executed and filed, with the material required, with the Commission at Washington prior to the hour of closing business on August 26, 1908. In applying for this examination the exact title as given at the head of this announcement should be used in the application.

Issued July 21, 1908.

A patient possessing gonorrhoea is not a criminal. He is an unfortunate. The laity will not separate the disease from the method of acquisition.—*Byron Robinson.*

For dilatation of the stomach and "overflow vomiting" subsequent to peritonotomy use frequently the stomach tube. Omit food per os and administer fluid per rectum "drop by drop method." Proctoclysis is the most valuable therapeutic agent in peritonotomy added during the last twenty-five years.—*Byron Robinson.*

LEUCORRHEA OF PREGNANCY.

Some women are troubled during the latter months of pregnancy with excessive vaginal secretion amounting in most cases to a catarrh. Every such a woman should be examined for gonorrhea—secretions from the os and the urethra to be subjected to microscopic test—because many such leucorrhœas are due to chronic infection with the gonococcus: and when so produced, will give the baby gonorrheal ophthalmia unless Crede's 10 per cent. solution of nitrate of silver be instilled in the child's eyes as soon as delivery is effected. In other cases the leucorrhœa seems to depend upon the excessive venous congestion, which is sometimes so great as to cause marked edema of the vulva during the later months of gestation.

When caused by Neisser a diplococcus, the most energetic measure must be instituted to eradicate the infection before labor occurs, else puerperal sepsis of dangerous character will almost inevitably follow delivery; special attention being directed to the urethra and to the cervix (the two chief foci of chronic infections), through the glands of Bartholin must not be neglected, the vagina being but rarely the site of a gonorrheal inflammation. When found to be caused by engorgement the leucorrhœa is best cured by rest in bed supplemented by vaginal douches of a solution of chlorate of potassium or of alum, to be followed in an hour or two by plain water. These douches should invariably be taken in the recumbent posture.—*American Journal of Clinical Medicine.*

A PLAN FOR REDUCING INFANT MORTALITY IN NEW YORK.

Wilbur C. Phillips, New York, gives a program that he hopes may be initiated in New York City, which will lessen infant mortality. The main feature will be copied from the French Consultations for Nursing Infants, which have been carried on so successfully in many districts of that country. The author believes that the furnishing of sterilized or pasteurized milk may act as a deterrent to mothers from nursing their children, the latter being the only really useful method of diminishing infant mortality. He describes the consultations and gives statistics of their results, which have been most excellent. What the poor woman needs is education about breast feeding, The author

advocates the establishment on a large scale of consultations for nursing infants, at which infants shall be weighed and advice given as to their care, the mothers emulating one another in getting the best looking babies. The mothers can be taught home pasteurizing of milk when they cannot nurse the child. Unselfish co-operation of physicians is necessary to teach the mothers. Next comes the production of modified pure milk at a cost that the poor mother can afford to pay. This will soon be accomplished by the New York Milk Committee's depots, which will be opened in June.—*Medical Record*, May 30, 1908.

The fading, atrophic appendix is supplied by arteries of a limited number and caliber. The general basis of perityphlitis is trauma of the psoas muscle with consequent perityphlitic peritoneal adhesions and resulting contractions compromising blood supply. Hence psoas trauma and vascular compromise is the general basic pathologic process preceding perityphlitis. The appendix in general is supplied by two arteries of extremely limited caliber. The appendicular arteries being of limited dimension are compromised with facility by the 72 per cent of peritoneal adhesions found adjacent to the right psoas muscle. The central factor in the aetiology is the trauma of the psoas muscle producing meso-perityphlitis (meso-appendicitis), which comprises the meso-appendicular vessels by meso-appendicular contractions, appendicular flexion, checking appendicular drainage and ending in appendicular perforation. It is surprising to observe the number of patients visiting one's office with the diagnosis of perityphlitis in whom no probable symptom of perityphlitis can be noted. Many of these are fake diagnoses for the purpose of securing an operation. Perityphlitis has at present become a "fad" and utilized to alarm the patient to seek an operation. It is true, this is not so irrational or criminal as to attempt to force a patient to have ovariectomy in order to secure an operation. Ovariectomy is in general, irrational, unphysiologic, cruel and criminal. However, many operations for appendicitis are absolutely unnecessary—simply prophylactic. The barbaric term "*Appendicitis*" should be replaced by the rational, philological term "*perityphlitis*," which would disarm the people from joining in the "fad operation." Certain country practitioners attend post-graduate schools sufficiently long—four weeks—to learn to incise the abdomen on numerous pretexts. Since

removing healthy appendices is not accompanied by much mortality the "business" is continued as profitable in *fee and fame*. Surely the unrighteous *appear* to prosper. Well, fraud gains not more than honesty.—*Byron Robinson*.

REMARKS OF MILK-FREE DIET AND RECTAL IRRIGATIONS IN TYPHOID FEVER.

Robert C. Kemp of New York, endorses the use of the milk-free diet in typhoid fever. In the acute stage of typhoid fever with diminished digestive power, fermentation and putrefaction of milk are increased by reason of the food remaining in the stomach for a longer period than is normal, through the motor function of the stomach being decreased. The author makes use of a milk-free diet with rectal irrigations and has excellent results therefrom.—*Medical Record*, June 20, 1908.

THE WINNING FIGHT AGAINST CONSUMPTION.

John B. Huber of New York, gives an excellent summary for the public of the causes of tuberculosis and the best methods for the public in combating it. Education is most important. The support of Boards of Health in their endeavors to suppress this disease is also important. In this work everyone should and may aid.—*Medical Record*, June 13, 1908.

Measured by every standard of purity, Peacock's Bromides is never successfully imitated. This is why it is necessary for the physician to see that the genuine is dispensed. He thus insures his results in all bromide treatment, particularly in those instances in which the prolonged use of the salts seems indicated and desirable. Neurologists have called especial attention to this feature of the preparation of Peacock's Bromides, and therefore it is extensively prescribed and dispensed in epilepsy. This is the severest therapeutic test to which the Bromides can be put, and there is no doubt that purity is of great importance in such cases.

Hysteria is the expression of one form of nervous debility. Celerina is thus peculiarly indicated because of its tonic effect on the whole nervous system.

CARDIAC TONIC.

"I have prescribed Cactina Pillets in a number of cases of heart trouble and find them a reliable cardiac tonic, especially in weak heart with small, frequent intermittent pulse. They are a specific in functional heart trouble."—R. A. Clopton, M. D., Milian, Tenn.

Acute Cystitis, in the Female is caused by various pathogenic bacteria, foreign bodies, traumatism, retention of urine, unclean catheters, exposure to cold, etc. The symptoms are frequent urination, with tenesmus and a burning sensation in the urethra, later on pain in the bladder, hematuria, and the urine contains pus and epithelial cells. Chills, rapid pulse, fever and headache may also be present. The treatment includes rest, administration of sanmetto, plenty of cold water or milk, bland and mild food, laxative, hot sitz baths or vaginal douches, irrigation of the bladder with antiseptic solution followed by solution of nitrate of silver.

RATIONAL TREATMENT OF INFANTILE DIARRHEA.

For years the treatment of diarrhea in children, commonly known as summer complaint, has been a stumbling block for the practitioner mainly because the true nature of the disease never was thoroughly understood. As a matter of fact, the prevention of the disease is quite easy, but as it depends altogether upon the parent who has the children in charge, neglect is always accountable for the sickness. The result is that the physician is seldom called until mischief has been done. Under the circumstances, rapid treatment has to be resorted to if fatalities are to be avoided. The main point is to modify the diet, suppressing objectionable food, particularly milk not properly modified in strength and sterilized. Meanwhile the bowels should be kept in a thoroughly aseptic condition. An experience of ten years or more has demonstrated that this is better accomplished through the use of Tyree's Antiseptic Powder; one teaspoonful or less of this powder diluted in a pint of tepid water makes an ideal washing for the intestine as an enema. Sample with chemical and bacteriological analysis sent upon request to J. S. Tyree, Chemist, Washington, D. C.

DENGUE FEVER AGAIN.

Many of the early symptoms of dengue are identical with those of yellow fever and it is often difficult in the early stages, to distinguish one from the other. However, Dr. Vernon E. Smith of Mt. Auburn, Ky., who has had a large experience with dengue, says that there is a marked difference between the two diseases and in an article in "Medical Progress" he points out the distinguishing features. He concludes by stating that: "The prognosis in dengue fever is generally favorable, although in the very aged and in the poorly nourished infant the termination is generally death. One attack does not preclude subsequent ones, for often there is a relapse during the stage of convalescence.

"The treatment is purely symptomatic as there is nothing that will cut short the attack. The greatest demand is for something to relieve the pain, and as a rule antikanina tablets have the desired effect. The temperature, if it runs high, should be reduced by means of the cold bath or sponging, and this should be repeated often enough to keep it down. If there is marked prostration this should be combated with stimulants, of which the alcoholic are the best. The application of heat by means of the hot water bath often gives marked relief. Sulphate of quinine administered during convalescence seems to assist recovery."

Prickly heat can be relieved and prevented by the use of Tyree's Antiseptic Powder. Dr. M. E. Chartier, of the Faculte de Paris, France, after using it successfully, says that it possesses curative and preventive properties to a high degree. This is the general opinion of all physicians who have tried Tyree's Antiseptic Powder in abrasions, burns, ulcers, and infected conditions of the skin and mucous membranes. Its high antiseptic properties make it one of the most powerful remedies at the command of the physicians for combating the effects of pathogenic micro-organisms after they have become active, and preventing the further growth and activity of pyogenic bacteria. It is not an expensive preparation, and therefore even long continued treatment can be carried out with comparatively small cost to the patient. Sample with chemical and bacteriological analysis sent upon request. J. S. Tyree, Chemist, Washington, D. C.